YEAR ONE • YEAR ONE • YEAR ONE • YEAR ONE •

Student Resource Guide

Direct Support Professional Training

California Department of Education

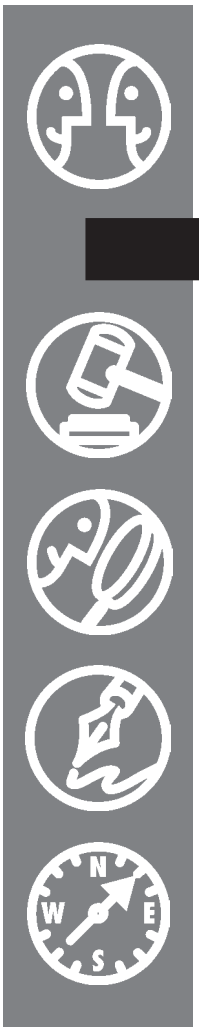
AND THE

Regional Occupational Centers and Programs

IN PARTNERSHIP WITH THE

Department of Developmental Services

UPDATED JANUARY 2004



Student Resource Guide, Year 1

Acknowledgements

The Department of Developmental Services (DDS) and the California Department of Education (CDE) would like to extend their appreciation to the many people and organizations throughout the state of California and across the nation who contributed their time and expertise to the initial development and revision of the Direct Support Professional Training. Special thanks are extended to:

- The California Legislature for their leadership in establishing this Direct Support Professional (DSP) Training Program.
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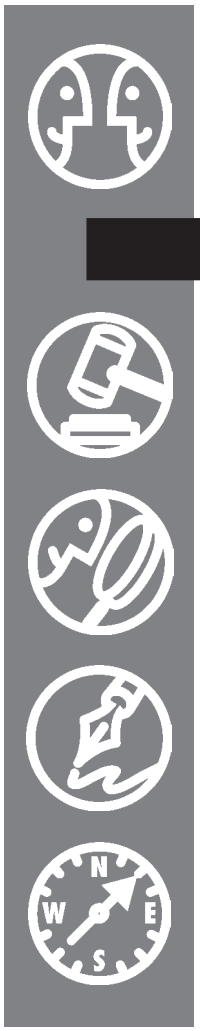
- The Department of Education's Regional Occupational Centers and Programs (ROCP) for their extraordinary commitment to implement this testing and training program. Special thanks and acknowledgement to the local ROCP coordinators and trainers who piloted the revised material.

Dedication

To everyone who is committed to improving the quality of life for individuals with developmental disabilities.



Student Resource Guide, Year 1

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Student Resource Guide, Year 1

Introduction

In 1998, the California Legislature established the Direct Support Professional (DSP) Training Program. The purpose of this program is to enhance quality of care for individuals with developmental disabilities living in licensed Community Care Facilities by ensuring core competencies or skills for all Direct Support Professionals. Upon successful completion of each of the two required 35-hour training segments, you will receive a Direct Support Professional Certificate.

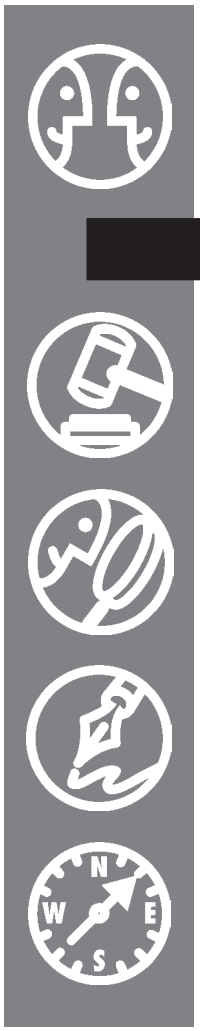
The Department of Developmental Services has engaged the California Department of Education's Regional Occupational Centers and Programs (ROCP) to provide the training in local communities. Each participating ROCP has established an Advisory Committee to assist in meeting community needs.

This Student Resource Guide includes extensive information in each of the training sessions including; expected outcomes, key words, in-class activities, practice and share, session review questions/answers, skill checks and additional reference and resource materials. These materials are to assist you, the Direct Support Professional, in meeting the challenges of your work.

This training is designed to provide the most current knowledge, ideas and resources as well as inspire your creativity and passion for your work. You are encouraged to use this opportunity for personal and professional development to expand your capacity to provide quality services and supports.

Dedication

To everyone who is committed to improving the quality of life for individuals with developmental disabilities.



Student Resource Guide

1. The Direct Support Professional

Student Resource Guide: SESSION 1

The Direct Support Professional

OUTCOMES

When you finish this session, you will be able to:

- Define the term "developmental disability."
- Identify characteristics of specific developmental disabilities.
- Identify the values of the California service system for individuals with developmental disabilities.
- Demonstrate awareness of your own attitudes and beliefs about others and how those attitudes and beliefs may impact your work.
- Describe your general role in the California service system for individuals with developmental disabilities.
- Identify ways to use ethics, observation, communication, decision making, and documentation in your work.
- Describe your role as a team member.
- Use "People First" language.
- Identify ways to determine how others would like to be treated.

KEY WORDS

Developmental Disability: A developmental disability begins before someone reaches 18 years of age; is something that goes on throughout a person's life; is a substantial disability for the individual; and often means there is a need for some kind of assistance.

Direct Support Professional (DSP): You are a DSP. A DSP works with and supports people with developmental disabilities where they live and work.

Individual: How this training refers to individuals with developmental disabilities. It will remind you to treat each person you support as an individual with unique interests, abilities, preferences, and needs.

People First Language: Language that refers to the qualities of a person, not a person's disabilities.

Platinum Rule: Treat others as they would like to be treated.

Professional Ethics: A set of standards to guide one's professional behavior.

Values: Ideals that shape the quality of services and supports.

Introduction

What is the reason for this Direct Support Professional training? There are two reasons, and they are connected to each other. The first is to help you do the best job you can in supporting individuals with developmental disabilities to have a better quality of life. The second reason is this: when you do the best job you are able to do, your professional life should be more rewarding, which should improve your quality of life. As a DSP there is something valuable in this training, not only for the individuals you are working with, but for yourself personally. There is nothing better than a situation in which everyone wins! We will begin the training by getting to know each other and learning more about what the training will cover.

ACTIVITY

Getting to Know You

Directions: Pair up with someone in the class. Take turns asking each other the followiing questions. Write your partner's answers below.

What is your name?

. . . . . .

Where do you work?

. . . . . .

What are three positive words that describe how you feel about the work you do?

1 . . . . . .

2 . . . . . .

3 . . . . . .

About the Training

The DSP training is 70 hours of training which is designed to be completed over a two-year period, 35 hours in each year. Each 35-hour training consists of eleven 3-hour class sessions and one 2-hour final test session. In Year 1, you will learn about:

- The Direct Support Professional.
- The California developmental disabilities service system.
- The Individual Program Plan.
- Risk management: principles and incident reporting.
- Environmental safety.
- Maintaining the best possible health.
- Dental health.
- Medication management.
- Communication.
- Positive behavior support.

In Year 2, you will learn more about those topics, as well as:

- Making choices.
- Person-centered planning.
- Nutrition and exercise.
- Strategies for successful teaching.
- Life quality.

Key Words

Each session will begin with "Key Words" in which words that are used in the session will be defined or described. For example, in this session the word **individual** is defined as "How this training refers to individuals with developmental disabilities. It will remind you to treat each person you support as an individual with unique interests, abilities, preferences, and needs."

You may use the words "consumers" or "clients" or some other word when referring to the individuals you support. However, throughout this training, individuals with developmental disabilities will be referred to as "individuals" or, in some instances, "people" or "person."

Homework

There will be no written homework in this training. However, you will be asked to practice at work what you have learned after each training session and share your experiences with the class.

Quizzes

At the end of each session, you will have a short quiz. The quiz questions will be multiple choice. We will go over the answers together in class.

Skill Checks

Skill checks are opportunities for your instructor to observe you demonstrating new and important skills. The following are two skill checks in the first year of training:

- Assisting with the self-administration of medication.
- Gloving procedures.

In Year II, you will repeat the skill check for assisting with the self-administration of medication because it is a very important skill. You must pass each skill check to pass the training.

Test After Training

The final test after the training consists of 36 multiple choice questions and is also on a Scantron® form. The questions on the test will be drawn directly from the quizzes.

About the Training

Word of Caution

Before we start the training, it is important to note that this training does not replace the professional advice of doctors, lawyers, and other experts. This training is based upon what are widely considered to be preferred practices. However, circumstances for each individual are unique and therefore require services and supports specifically designed to meet that individual's needs.

As policies and procedures differ from facility to facility, it is expected that you will familiarize yourself with the policies of the facility where you work. It is possible that some practices in your facility may differ from preferred practices that you learn in this training. What should you do? Start by talking to the administrator of the home where you work about these differences and the best course of action. And remember: never risk your health and safety, or that of an individual, to do something for which you feel unqualified. It is always okay to ask for help.

DSP Training for a Better Quality of Life

So what does "quality of life" mean? It means different things to different people. Generally, people experience a good quality of life when they:

- Are able to make choices in their lives, and their choices are encouraged, supported, and respected.
- Have close, supportive relationships with friends and family.
- Live in a home that is comfortable for them and with people who know and care about them.
- Participate in activities they find enjoyable.
- Have access to health care and have the best possible health.
- Feel and are safe.
- Are treated with dignity and respect.
- Are generally satisfied with their lives.

ACTIVITY

Directions: Think about what "quality of life" means for you. Write down five things that are important in your life (things that you think are necessary for you to have good quality of life).

1. . . . . .

2. . . . . .

3. . . . . .

4. . . . . .

5. . . . . .

Now let's see what some people with developmental disabilities have to say about what quality of life means to them. In 2003, a number of individuals with developmental disabilities living throughout the state of California were asked, "What does quality of life mean to you? What things are important in your life (things that you think are necessary for you to have good quality of life)?" This is what they said:

I choose my own friends 

I do what I want on  weekends

I spend my own  money

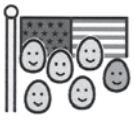
I  cook whenever I want

I  eat out

I decide how to spend my own  free time

I live where I want  to live

I make my own  decisions

I have the  freedom to work  when I want

I work where I want to work 

I can  go to college

DSP Training for a Better Quality of Life (continued)

In many of the above areas, the individuals surveyed felt they were doing pretty well; however, individuals said they specifically wanted more choices in the area of relationships, personal care, and personal freedom.

In the area of relationships, they wanted to spend more time with friends, see their families more often and at holidays, spend some time with boyfriends and girlfriends, and get married.

In the area of personal care they wanted better trained doctors and more of them, good healthy food available, and more recreational opportunities.

In the area of personal freedom, they wanted to spend more time in the community, to make their own decisions about when to go on a diet, to go on more vacations, and to be more a part of their communities.

People wanted to say some very specific things to the people who support them: that means you. They want to have more say about the medications they take; to wear clean clothes; to decide on their own bedtime and not to have a schedule; to watch the television programs they like at the times they want; to see boyfriends and girlfriends when they want; and, to invite more visitors to come over to visit.

Exerpted and Adapted from Department of Developmental Service's Consumer Advisory Committee, *Community Conversations with People with Developmental Disabilities in California.*

As we go through this training, listen, learn, and think about what individuals with developmental disabilities have to say about what is important to them and how you can apply what you learn in supporting the individuals you serve to lead quality lives.

The Direct Support Professional

A **Direct Support Professional** (DSP) works with and supports individuals in the places they live and work. DSPs perform their jobs in licensed homes, day programs, supported or independent living environments, or work sites. A DSP has many important roles to play. You are:

- A PARTNER, supporting individuals in leading independent lives and participating in and contributing to the community.
- A TEACHER, finding creative and fun ways to help individuals learn meaningful skills and providing them with information to make the best choices for themselves.
- An AMBASSADOR to the individual's community, encouraging others to support individuals with developmental disabilities as neighbors, friends, and co-workers.
- An ADVOCATE, supporting individuals in exercising their rights and responsibilities.
- A SUPPORTER seeking to understand the likes, dislikes, hopes, and dreams of individuals you support and cheering individuals on as they make progress toward their life goals.

All of the roles that you play have a common focus on supporting individuals to live the kind of life they hope and dream about. The DSP is a Partner, Teacher, Ambassador, Advocate, and Supporter. The DSP is *not* a Boss or one who orders people around and makes them do things they may or may not want to do. Likewise, the DSP is *not* a Parent to the people they support. The job of the DSP carries a great deal of responsibility, and it is easy to get these roles confused. Unlike a parent, legal guardian, or conservator, the DSP does not have the responsibility to make important life decisions for individuals they work for and with. Instead, the individuals themselves, with the help of parents, legal guardians, or conservators, as appropriate, make decisions about their own lives.

OPTIONAL ACTIVITY

DSP Roles and Responsibilities

Directions: Read the following scenario. Draw a line from each activity to its matching role. Some roles will have more than one activity attached to them.

Mary, a new DSP, asks her co-worker, Tom, to tell her about what he does during a typical work day. She wants to know more about what she's expected to do as a DSP. Tom counts on his fingers some of the activities he did over the past week. As he lists the activities, he realizes that he doesn't have enough fingers to count them all! Here are some of the activities Tom did:

ROLES

Partner

Teacher

Ambassador

Advocate

Supporter

- Tom talked to Martha, the Home Administrator, about getting ready for A.J.'s IPP meeting scheduled for Tuesday. Tom would like to see A.J. get a bus pass for the Roseland area now that he uses the bus to go to work.
- Tom helped A.J. with his medication.
- Tom spent time teaching A.J. how to put a tape into his own VCR.
- Tom helped A.J. and Marissa make breakfast.
- Tom talked with Marissa about her parents. Marissa feels that her parents are too controlling.
- Tom helped A.J. clean up his room.
- Tom talked to Martha about tacking down a piece of carpet that A.J. tripped over.
- Tom helped A.J. pick out matching clothes to wear.
- Tom talked to A.J.'s boss at Starbucks. He answered his questions about A.J.'s disability.
- A.J.'s Service Coordinator was late for an appointment, and Tom could tell that A.J. was upset. Tom went for a short walk with A.J. to help him settle down.
- Tom helped Marissa make a list of questions for the doctor before he took her to her appointment.

Teaming with Others to Support Individuals

Another important role that the DSP plays is that of a Team Member. As a DSP, you are a member of several teams: the team of staff who work to support individuals in the home, each person's individual support team, and each individual's planning team.

People who might be part of these teams include: individuals and their families; the administrator of the home and other DSPs, both in the home and at a day or work site; regional center staff consultants, health care professionals, and other representatives from community agencies.

You will find that working as part of a team is often better than working alone. Sharing information and ideas with team members leads to creative planning and problem solving.

The DSP Profession

People like you, who support individuals in their daily lives, were not always considered "professionals." More recently, the importance of the challenging work that you and other DSPs perform has gained broad recognition and acknowledgement as a profession.

Specific knowledge, skills, and commonly agreed-upon standards for professional conduct are what separate a "job" from a "profession." This training focuses on the skills, knowledge, and abilities that have been identified by administrators, direct support professionals, and others as critical to satisfactory job performance.

Nationwide, DSPs have joined together to form a professional organization called the National Alliance for Direct Support Professionals (NADSP). The NADSP has developed a set of **professional ethics** (standards for professional conduct) for DSPs.

The complete text of the NADSP Code of Ethics is in Appendix 1-A. Information about how to get connected with this organization is included in the Resources section. NADSP has a Web site and newsletter written by and for DSPs that contains very helpful and supportive information for DSPs.

Values to Guide Your Work

The Lanterman Developmental Disabilities Services Act, which became law in the 1970s, establishes the state's promise to Californians with developmental disabilities to provide quality services to meet their individual needs. The Lanterman Act envisions services that reflect the values of individual choice, relationships, regular lifestyles, health and well-being, rights and responsibilities, and satisfaction. **Values** are ideals that shape the quality of services and supports. Here is what the Lanterman Act says about the value of:

Choice:

Services and supports should be based on the individual and his/her needs and preferences.

Individuals (with help from parents, legal guardians, or conservators when needed) should take part in decisions about their own lives, such as where and with whom they live, where they work, their relationships with others, the way in which they spend their time, and their goals for the future.

Relationships:

Individuals with developmental disabilities have the right to develop relationships, marry, be a part of a family, and be a parent if they choose.

Support may be needed to develop intimate relationships, such as transportation, family counseling, or training in human development and sexuality.

Support may be needed to help people start and keep relationships with friends and fellow community members.

Regular Lifestyles:

Individuals should have a chance to be involved in the life of their community in the same ways as their neighbors, friends, and fellow community members.

Services should be provided whenever possible in the home and community settings where individuals live and work.

Cultural preferences should be honored.

Individuals should have the training needed to be as independent and productive as possible.

When an individual needs change, services should be changed as well to make sure that the individual can continue living where he or she chooses.

Individuals should be comfortable where they live, have privacy when they need it, and should have a say in the way their living spaces are decorated and arranged.

There should be services and supports that allow minors with developmental disabilities to live with their families whenever possible.

Health and Well-Being:

Individuals have a right to be free from harm and live a healthy lifestyle.

Individuals should have a right to quick medical, mental, and dental care and treatment when they need it.

Individuals should have a chance to learn how to keep themselves healthy, or have services and supports that keep them healthy.

Values to Guide Your Work (continued)

Rights and Responsibilities:

Individuals with developmental disabilities have the same basic legal rights as other citizens.

Individuals have a right to privacy and confidentiality of personal information.

Individuals have a right to treatment and habilitation, dignity, privacy, and humane care; prompt medical care and treatment; religious freedom; social interaction; physical exercise; and to be free from harm.

Individuals have the right to make choices in their own lives, such as where to live, who to live with, education and employment, leisure, and planning for the future.

Along with all of these rights are responsibilities, such as respecting the privacy of others and being an informed voter.

Individuals should have a chance to learn about their rights and responsibilities and how to advocate for themselves.

Satisfaction:

Individuals should have a chance to plan goals for the future and to work toward them.

Individuals should be satisfied with the services and supports they receive and should have a chance to change them when they are not satisfied.

Individuals should have a chance to have a good quality life.

Adapted from *Looking at Life Quality*, Department of Developmental Services (1996).

Supporting individuals in having quality of life means supporting them in ways that are consistent with these values: making sure that individuals have choices, spend time with family and friends, have the best possible health, are safe, and are treated with dignity and respect… all the things that are necessary for quality of life.

DSP Toolbox

Whether you are working inde pendently or with a team, you will need a set of "tools"—basic skills and knowledge—to help you successfully meet the daily challenges of your job. Just as a carpenter cannot do a job without a hammer and nails, a DSP cannot provide the best possible support to individuals without the DSP tools.Tools in the DSP Toolbox are:

Ethics: enable the DSP to make ethical decisions.

Observation: enables the DSP to observe people and places for things that could affect individual's health and well-being.

Communication: enables the DSP to communicate in a variety of ways.

Decision making: enables the DSP to choose the best course of action with the information at hand.

Documentation: enables the DSP to document important information about individuals and events.

Many situations in your work call for using several tools at the same time. For example, if an individual is sick, you might use every tool in the DSP Toolbox.

- ***Ethics*** to guide you in promoting the individual's physical well-being by identifying the illness and ensuring timely medical treatment with dignity and respect.
- ***Observation*** by using your senses to identify changes that are likely to be signs and symptoms of illness. You might *see* the individual rubbing her stomach, *feel* her skin is cold and clammy, or *hear* her moaning and saying "my stomach hurts."
- ***Communication*** to ask questions about someone's pain such as, "How long has it hurt you?" Communication also means listening and understanding an individual's response.
- ***Decision making*** to decide how to respond to the individual's illness based on what you have observed and what has been communicated. For example, "Do I need to call the doctor or take her directly to the emergency room?"
- ***Documentation*** to record information about the illness in the individual's daily log and on an information sheet to bring to the doctor's appointment.

Ethics

***Ethics** are rules about how people think they and others should behave. People's ethics are influenced by a variety of factors including culture, education, and the law.*

- The NADSP developed a Code of Ethics (Appendix 1-A) to guide the behavior of DSPs. Refer to the Code when in doubt about the most ethical thing to do.
- Here is a condensed version of the NADSP Code of Ethics:
  1. *Advocacy:* As a DSP, I will work with the individuals I support to fight for fairness and full participation in their communities.
  2. *Person-Centered Supports:* As a DSP, my first loyalty is to the individual I support. Everything I do in my job will reflect this loyalty.
  3. *Promoting Physical and Emotional Well-Being:* As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of individuals receiving support while being attentive and energetic in reducing their risk of harm.
  4. *Integrity and Responsibility:* As a DSP, I will support the mission of my profession to assist individuals to live the kind of life they choose. I will be a partner to the individuals I support.
  5. *Confidentiality:* As a DSP, I will protect and respect the confidentiality and privacy of the individuals I support.
  6. *Fairness:* As a DSP, I will promote and practice fairness for the individuals I support. I will promote the rights and responsibilities of the individuals I support.
  7. *Respect:* As a DSP, I will respect the individuals I support and help others recognize their value.
  8. *Relationships:* As a DSP, I will assist the individuals I support to develop and maintain relationships.
  9. *Self-Determination:* As a DSP, I will assist the individuals I support to direct the course of their own lives.

Observation

***Observation** is noticing change in an individual's health, attitude, appearance, or behavior.*

- Get to know the individual so you can tell when something changes.
- Use your senses of sight, hearing, touch, and smell to observe signs or changes.
- Get to know the individual's environment and look for things that may impact an individual's and other's safety and well being.

Communication

***Communication** is understanding and being understood.*

- Listen carefully to what is being communicated through words and behavior.
- Repeat back what was communicated to confirm understanding.
- Ask questions to gain a more complete understanding.
- Be respectful.

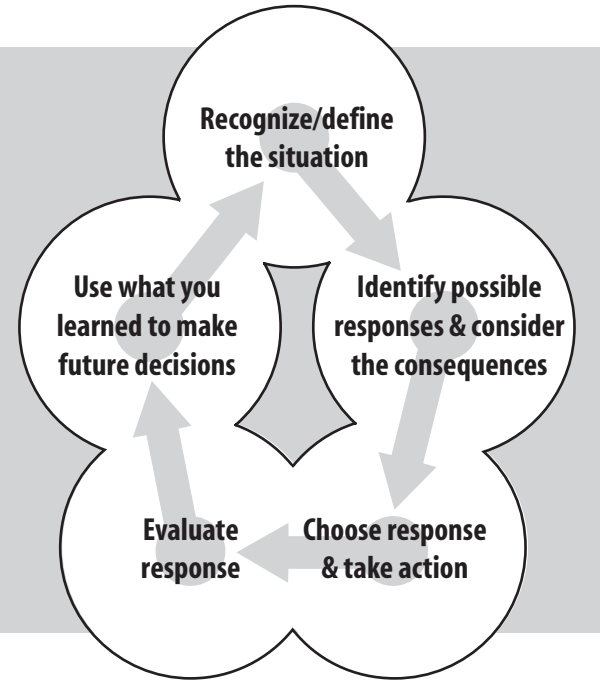
DSP Toolbox: Additional Information

Decision making

Decision making *is choosing the best response to a situation with the information that is available to you. Decision making is an ongoing process.*

- Recognize/define the situation.
- Identify possible responses and consider the consequences.
- Choose a response and take action.
- Evaluate how your response worked. Were the consequences positive? If not, what could have made it work better?
- Use what you learned to make decisions in the future.

DECISION MAKING LOOP



Documentation

Documentation *is a written record.*

- The DSP is required to keep consumer notes for the following important, non-routine events in an individual's life: medical and dental visits, illness/injury, special incidents, community outings, overnight visits away from the home, and communications with the individual's physician.
- Do not document personal opinions, just the facts (for example, who, what, when, and where).
- Be specific when describing behaviors.
- Record what the person actually said or describe non-verbal attempts to communicate.
- Describe the event from beginning to end.
- Be brief.
- Use ink.
- Do not use White Out® to correct mistakes. Cross out the error and put your initials next to it.
- Sign or initial and date.

See Appendix 1-A for an examples of blank and completed consumer notes forms.

Individuals with Developmental Disabilities

Who are the people you support? First, they are **individuals**. The people you support are children and adults, male and female, and come from interesting backgrounds just like you. They have many unique preferences and qualities that you will get to know as you get to know them. What the individuals you support have in common is that they have developmental disabilities.

Here is some basic information about the causes and kinds of developmental disabilities. You are not expected to know everything about every type of developmental disability. However, it is important that you know and understand the types of disabilities that the individuals you work with have in order to provide them with the best possible service and support.

What Is a Developmental Disability?

A **developmental disability**, as defined by California state law:

- Begins before someone reaches 18 years of age.
- Is something that goes on throughout an individual's life.
- Is a substantial disability for the individual.
- Often means there is a need for some kind of assistance in the individual's daily life.

Developmental disabilities include mental retardation, cerebral palsy, epilepsy, and autism. Also included in the legal definition are people who need the same kinds of support as those who have mental retardation. It does not include people who have only physical, learning, or mental health challenges.

Causes of a Developmental Disability

Many things can cause a developmental disability, such as:

- The mother having a serious illness, poor eating habits, or poor health care, or the fact that she smokes, drinks alcohol, or uses drugs.
- Chemical or chromosomal differences (like Downs Syndrome) or an inherited condition.
- A lack of oxygen to the brain, low weight, or a difficult birth.
- A serious accident, abuse, lead poisoning, or poor nutrition.

While keeping the above causes in mind, remember that often, the cause is not known. A developmental disability can happen in any family.

Major Kinds of Developmental Disabilities

The following graph illustrates the major kinds of developmental disabilities: mental retardation, cerebral palsy, autism and epilepsy. The graph also tells you what those disabilities might look like and how that might impact how you support individuals.

Developmental Disability	*Characteristics*	*Notes for the DSP*
Mental Retardation	• Learns slowly. • Has a hard time remembering things that are learned. • Has a hard time using what is learned in a new situation. • Thinks about things in more real-life or concrete ways. • Keeps learning and developing throughout life as we all do.	• There are different levels of mental retardation from mild to moderate to severe. This means that individuals need different types of assistance in daily living. • Very different from mental illness. Some people who have mental retardation also have mental illness, but most people who have mental illness do not have mental retardation.
Cerebral Palsy	• Awkward or involuntary movements. • Poor balance. • An unusual walk. • Poor motor coordination. • Speech difficulties.	• "Cerebral" refers to the brain and "palsy" to a condition that affects physical movement. • Ranges from mild to severe. • Not a contagious disease—you can't "catch" it. • People can lead more independent lives through physical therapy and the use of special devices (for example, computers and wheelchairs). • May also have mental retardation and/or epilepsy.
Autism	• Generally has a difficult time making friends. • May have unusual emotional responses, such as laughing at a car accident. • Generally has a difficult time communicating with other people. • May hurt self (self-injurious). • Generally wants to follow routines and gets upset if things get changed. • May repeat words and/or body movements.	• Affects people in many different ways. The causes are not very well understood. • Some people who have autism also have mental retardation.
Epilepsy	• Has seizures. • May become unconscious. • Movement or actions may change for a short time.	• Epilepsy is sometimes called a seizure disorder. • Individuals with epilepsy may also have mental retardation, cerebral palsy, or autism.
Other		• Includes people who need the same kinds of support as those who have mental retardation. • It does not include people who have only physical, learning, or mental health challenges. • Examples are conditions like Neurofibromatosis, Tuberous Sclerosis, and Prader-Willi Syndrome.

Developmental Delays

A developmental delay is a very large difference between a young child's abilities and what is usually expected of children the same age. ("Young" is defined as up to 36 months of age.)Infants and toddlers who have a developmental delay can receive early intervention services. These services support the child in learning the things that will help him or her start to catch up.

Individuals with Developmental Disabilities Are People First

While it's important to learn about the names and causes of developmental disabilities, **individuals with developmental disabilities are people first**. One group of self-advocates came up with the saying, "Label Jars, Not People." For example, the subtle difference between calling Joe "a person with autism" rather than "an autistic person" is one that acknowledges Joe as a person first. This is one example of what is called **People First Language**. A good way to ensure that you are using People First Language is to begin describing people with the words "individual," "person," "man," or "woman."

The Golden Rule vs. the Platinum Rule

It is not enough to use People First Language to show respect for individuals. It is also important to demonstrate **People First Behavior**. What does that mean? It means that:

- You take the time to learn about an individual's needs, strengths, and preferences.
- You do not assume that you know what is best.
- Your manner of supporting individuals reflects their needs, strengths, and preferences.

The old rule was the **Golden Rule**: Treat others the way you would want to be treated. The new rule is the **Platinum Rule**: Treat others as they want to be treated.

OPTIONAL ACTIVITY

Stereotypes of Individuals with Developmental Disabilities

Directions: Write down the stereotypes of people with developmental disabilities that you have heard and then consider the following questions.

How many stereotypes are negative?

Why are so many negative?

What impact does it have on the people whom you work with if you believe these stereotypes?

Does anyone know of a person without a disability who fits one or more of these stereotypes?

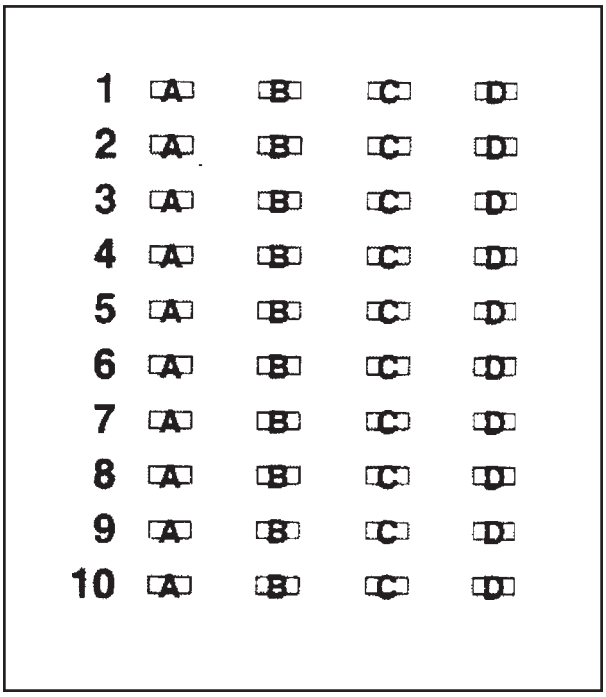
Do you think these stereotypes ever affect the work that DSPs do? If so, how?

How can DSPs overcome these stereotypes?

PRACTICE AND SHARE

Think of a time when you helped to add to the quality of an individual's life. What exactly did you do to add to the quality of the individual's life? How do you know it added to the quality of the individual's life?

The DSP Profession



1. **What is the main reason DSPs are required to take the DSP Training?**
   A) To help the DSP improve the quality of life of individuals with developmental disabilities.
   B) To give the DSP firm control over the lives of individuals with developmental disabilities.
   C) To enable DSPs to earn more money for the work they do.
   D) To reduce the responsibility DSPs have for caring for individuals with developmental disabilities.

2. **Which of the following is a value that is reflected in the Lanterman Developmental Disabilities Services Act?**
   A) Others deciding what friends an individual may associate with.
   B) Requiring an adult to be obedient to his or her parents.
   C) Making sure the lifestyle of the person is completely free of risk.
   D) Making sure individuals are satisfied with their services and supports.

3. **Which of the following is a role the DSP is expected to play?**
   A) Advocate
   B) Parent
   C) Boss
   D) Disciplinarian

4. **Which of the following is an example of "People First" Language?**
   A) Victim
   B) Handicapped
   C) Individual with a developmental disability
   D) Mentally retarded person

5. **Which of the following is true about developmental disabilities?**
   A) Developmental disabilities always begins before someone is born.
   B) Individuals usually outgrow developmental disabilities by the time they retire.
   C) Individuals with developmental disabilities are capable of learning and growing.
   D) Most individuals with severe to profound developmental disabilities need very little assistance in their daily lives.

6. **Wanda has difficulty walking and speaking clearly. Sometimes she jerks her head to the side and moves her arms around even though she does not intend to make these movements. Based upon this description, which one of the following disabilities is Wanda most likely to have?**
   A) Mental retardation
   B) Cerebral Palsy
   C) Autism
   D) Epilepsy

Continued ▶

Read this story and then answer questions 7 through 10..

Mary noticed that Marissa was rubbing her knee. She asked Marissa why she was doing that. Marissa answered that she had tripped on a crack in the sidewalk, fallen, and hurt her knee. Marissa asked her to show her what her knee looked like. There was a very large bruise and swelling. Mary called the doctor to make an appointment for that day and tried to make Marissa comfortable until the appointment. Later, Mary wrote about what happened in the staff log so that DSPs working the next shift would be informed.

7. **When Mary noticed that Marissa was rubbing her knee, she was using _____ from the DSP Toolbox.**
   A) Documentation
   B) Ethics
   C) Decision making
   D) Observation

8. **When Mary asked Marissa why she was rubbing her knee, she was using _____ from the DSP Toolbox.**
   A) Ethics
   B) Communication
   C) Observation
   D) Decision making

9. **When Mary looked at Marissa's knee and called the doctor, she was using _____ from the DSP Toolbox.**
   A) Observation
   B) Communication
   C) Documentation
   D) Decision making

10. **When Mary made a doctor"s appointment for the same day and tried to make Marissa comfortable before the appointment, she was using _____ from the DSP Toolbox.**
    A) Communication
    B) Observation
    C) Ethics
    D) Documentation

Appendices

Appendix 1-A

National Alliance of Direct Support Professionals

CODE OF ETHICS

Advocacy

As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation.

Interpretive Statements

As a DSP, I will –

- Support individuals to speak for themselves in all matters where my assistance is needed.
- Represent the best interests of people who cannot speak for themselves by finding alternative ways of understanding their needs, including gathering information from others who represent their best interests.
- Advocate for laws, policies, and supports that promote justice and inclusion for people with disabilities and other groups that have been disempowered.
- Promote human, legal, and civil rights of all people and assist others to understand these rights.
- Recognize that those who victimize people with disabilities either criminally or civilly must be held accountable for their actions.
- Find additional advocacy services when those that I provide are not sufficient.
- Consult with people I trust when I am unsure of the appropriate course of action in my advocacy efforts.

Person-Centered Supports

As a DSP, my first allegiance is to the person I support; all other activities and functions I perform flow from this allegiance.

Interpretive Statements

As a DSP, I will –

- Recognize that each person must direct his or her own life and support and that the unique social network, circumstances, personality, preferences, needs and gifts of each person I support must be the primary guide for the selection, structure, and use of supports for that individual.
- Commit to person-centered supports as best practice.
- Provide advocacy when the needs of the system override those of the individual(s) I support, or when individual preferences, needs, or gifts are neglected for other reasons.
- Honor the personality, preferences, culture, and gifts of people who cannot speak by seeking other ways of understanding them.
- Focus first on the person and understand that my role in direct support requires flexibility, creativity, and commitment.

Promoting Physical and Emotional Well-Being

As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of the individuals receiving support. I will encourage growth and recognize the autonomy of the individuals receiving support while being attentive and energetic in reducing their risk of harm.

Interpretive Statements

As a DSP, I will –

- Develop a relationship with the people I support that is respectful and based on mutual trust and that maintains professional boundaries.
- Assist the individuals I support to understand their options and the possible consequences of these options as they relate to their physical health and emotional well-being.
- Promote and protect the health, safety, and emotional well-being of an individual by assisting the person in preventing illness and avoiding unsafe activities. I will work with the individual and his or her support network to identify areas of risk and to create safeguards specific to these concerns.
- Know and respect the values of the people I support and facilitate their expression of choices related to those values.
- Challenge others, including support team members (for example, doctors, nurses, therapists, co-workers, or family members) to recognize and support the rights of individuals to make informed decisions even when these decisions involve personal risk.
- Be vigilant in identifying, discussing with others, and reporting any situation in which the individuals I support are at risk of abuse, neglect, exploitation, or harm.
- Consistently address challenging behaviors proactively, respectfully, and by avoiding the use of aversive or deprivation intervention techniques. If these techniques are included in an approved support plan I will work diligently to find alternatives and will advocate for the eventual elimination of these techniques from the person's plan.

Integrity and Responsibility

As a DSP, I will support the mission and vitality of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals, and the community.

Interpretive Statements

As a DSP, I will –

- Be conscious of my own values and how they influence my professional decisions.
- Maintain competency in my profession through learning and ongoing communication with others.
- Assume responsibility and accountability for my decisions and actions.
- Actively seek advice and guidance on ethical issues from others as needed when making decisions.
- Recognize the importance of modeling valued behaviors to co-workers, persons receiving support, and the community-at-large.
- Practice responsible work habits.

Confidentiality

As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support.

Interpretive Statements

As a DSP, I will –

- Seek information directly from those I support regarding their wishes in how, when, and with whom privileged information should be shared.
- Seek out a qualified individual who can help me clarify situations where the correct course of action is not clear.
- Recognize that confidentiality agreements with individuals are subject to state and agency regulations.
- Recognize that confidentiality agreements with individuals should be broken if there is imminent harm to others or to the person I support.

Justice, Fairness, and Equity

As a DSP, I will promote and practice justice, fairness, and equity for the people I support and the community as a whole. I will affirm the human rights, civil rights, and responsibilities of the people I support.

Interpretive Statements

As a DSP, I will -

- Help the people I support by using the opportunities and the resources of the community available to everyone.
- Help the individuals I support understand and express their rights and responsibilities.
- Understand the guardianship or other legal representation of individuals I support, and work in partnership with legal representatives to assure that the individual's preferences and interests are honored.

Respect

As a DSP, I will respect the human dignity and uniqueness of the people I support. I will recognize each person I support as valuable and help others understand their value.

Interpretive Statements

As a DSP, I will –

- Seek to understand the individuals I support today in the context of their personal history, their social and family networks, and their hopes and dreams for the future.
- Honor the choices and preferences of the people I support.
- Protect the privacy of the people I support.
- Uphold the human rights of the people I support.
- Interact with the people I support in a respectful manner.
- Recognize and respect the cultural context (such as, religion, sexual orientation, ethnicity, socioeconomic class) of the person supported and his or her social network.
- Provide opportunities and supports that help the individuals I support be viewed with respect and as integral members of their communities.

Relationships

As a DSP, I will assist the people I support to develop and maintain relationships.

Interpretive Statements

As a DSP, I will –

- Advocate for the people I support when they do not have access to opportunities and education to facilitate building and maintaining relationships.
- Assure that people have the opportunity to make informed choices in safely expressing their sexuality.
- Recognize the importance of relationships and proactively facilitate relationships between the people I support, their family, and friends.
- Separate my own personal beliefs and expectations regarding relationships (including sexual relationships) from those desired by the people I support based on their personal preferences. If I am unable to separate my own beliefs /preferences in a given situation, I will actively remove myself from the situation.
- Refrain from expressing negative views, harsh judgments, and stereotyping of people close to the individuals I support.

Self-Determination

As a DSP, I will assist the people I support to direct the course of their own lives.

Interpretive Statements

As a DSP, I will –

- Work in partnership with others to support individuals leading self-directed lives.
- Honor the individual's right to assume risk in an informed manner.
- Recognize that each individual has potential for lifelong learning and growth.

Student Resource Guide

2. The California Developmental Disabilities Service System

Student Resource Guide: SESSION 2

The California Developmental Disabilities Service System

OUTCOMES

When you finish this session you will be able to:

- ▶ Identify agencies and people involved in the California service system.
- ▶ Describe the functions of the regional centers.
- ▶ Identify legal requirements that directly relate to DSP responsibilities.
- ▶ Demonstrate understanding of the purpose of the Individual Program Plan (IPP).
- ▶ Identify the members of the individual's planning team.
- ▶ Identify rights of individuals with developmental disabilities and understand the DSP's responsibilities in supporting those rights.

KEY WORDS

Community Care Facilities: Homes operated by people or agencies who are granted a license by the State of California to provide residential care.

Confidentiality: Not sharing information about an individual without permission to do so.

Denial of Rights: Process where a right may be denied for a limited period of time, under a very narrow set of circumstances, and only under certain conditions which are documented and approved by the regional center.

Goal: Accomplishments that are important to the individual, reflecting the individual's needs and preferences.

Individual Program Plan (IPP): A written agreement, required by the Lanterman Act, between the individual and the regional center and developed by the planning team that lists the individual's goals and the services and supports needed to reach those goals.

Individual's Rights: Specific rights, granted by the Lanterman Act to individuals who are developmentally disabled to ensure that they are treated like everyone else; for example, the right to dignity and humane care.

Legally Authorized Representative: parent(s) or legally appointed guardian of a minor child, or legally appointed conservator of an adult.

Person-Centered: The concept that the individual with the developmental disability is the most important person in both planning for and provision of services.

Planning Team: A group of people that must include the individual, the legally authorized representative (parent of a minor, guardian of a minor, or conservator of an adult) if applicable, and the regional center service coordinator who come together to plan for and support the needs and preferences of the individual.

Preferences: Choices that the individual makes.

Regional Center: A group of 21 centers throughout California, created by the Lanterman Act, that helps individuals with developmental disabilities and their families find and access services.

Service Coordinator: An individual who works with individuals and families to find and coordinate needed services and supports.

Services and Supports: Assistance and help needed for the individual to lead the most independent and productive life possible, based on the individual's wants, needs, and desires.

Title 17: A set of regulations that establishes requirements for regional centers and regional center vendors including vendored community care facilities.

Title 22: A set of regulations that establishes requirements for licensed community care facilities.

California Developmental Disabilities Services System

In the last session we talked about the values for the developmental services system that have been established in the Lanterman Act. In this session, you will learn about the system of services for coordinating and planning services and supports for individuals with developmental disabilities and their families.

The California State Legislature passed the Lanterman Act to create a network of agencies responsible for planning and coordinating services and supports for individuals with developmental disabilities and their families.

The developmental disabilities service system includes the following agencies and organizations:

- Department of Developmental Services
- Regional centers
- Regional center vendors
- State Council on Developmental Disabilities
- Area boards
- Protection and advocacy

The Department of Developmental Services (DDS) provides leadership, oversight, coordination, and funding for regional centers. The Department of Developmental Services writes regulations or rules for regional centers and regional center vendors. These regulations are typically referred to as **Title 17**. You need to be familiar with Title 17 because it has requirements for how you do your job. [Information about how to get a copy of Title 17 is included in Appendix 2-B.]

There are 21 regional centers located throughout the state. **Regional centers** establish eligibility and provide a variety of services to eligible individuals and their families including assessment, advocacy, planning, purchase of services from vendored (contracted) service providers, and service coordination. A **service coordinator** coordinates the activities necessary to develop and implement an **Individual Program Plan (IPP)** for each person served by the regional center.

The Individual Program Plan is developed by the individual and his or her planning team. The IPP states the goals that a person is trying to achieve and plans for achieving those goals. The regional center may assist the individual to access generic services (services that are used by everyone in the community) or may directly purchase a service.

Regional centers may purchase many different types of services to meet individual needs. Among these services are:

- Early Intervention services—Infant development programs, and preschools.
- Health-related services—Assessment and consultation from doctors and other health care professionals as needed.
- In-home support services—Respite and family support.
- Day and vocational services—Day program services, independent living services, habilitation services, supported employment, and work activity programs.
- Residential services—Supported living services, adult family home services, and community care facilities

Many different agencies and individuals are vendored (or contracted) with regional centers to provide these services. The community care facility in which you work is one of about 4,500 licensed community care facilities vendored with the regional centers to provide residential services.

California Developmental Disabilities Services System (continued)

Regional centers have a responsibility to ensure the quality of services provided by vendors to individuals. The Lanterman Act requires regional centers to make at least two unannounced visits a year to vendored **community care facilities**—the places where you work—and to regularly monitor services to ensure they are of good quality and that individuals and their families are satisfied.

The Lanterman Act also provides for advocacy through the State Council on Developmental Disabilities, area boards and protection and advocacy. All have a responsibility to advocate on behalf of individuals with developmental disabilities and their families to ensure that their service needs are being met, that services are of good quality and that rights are being respected.

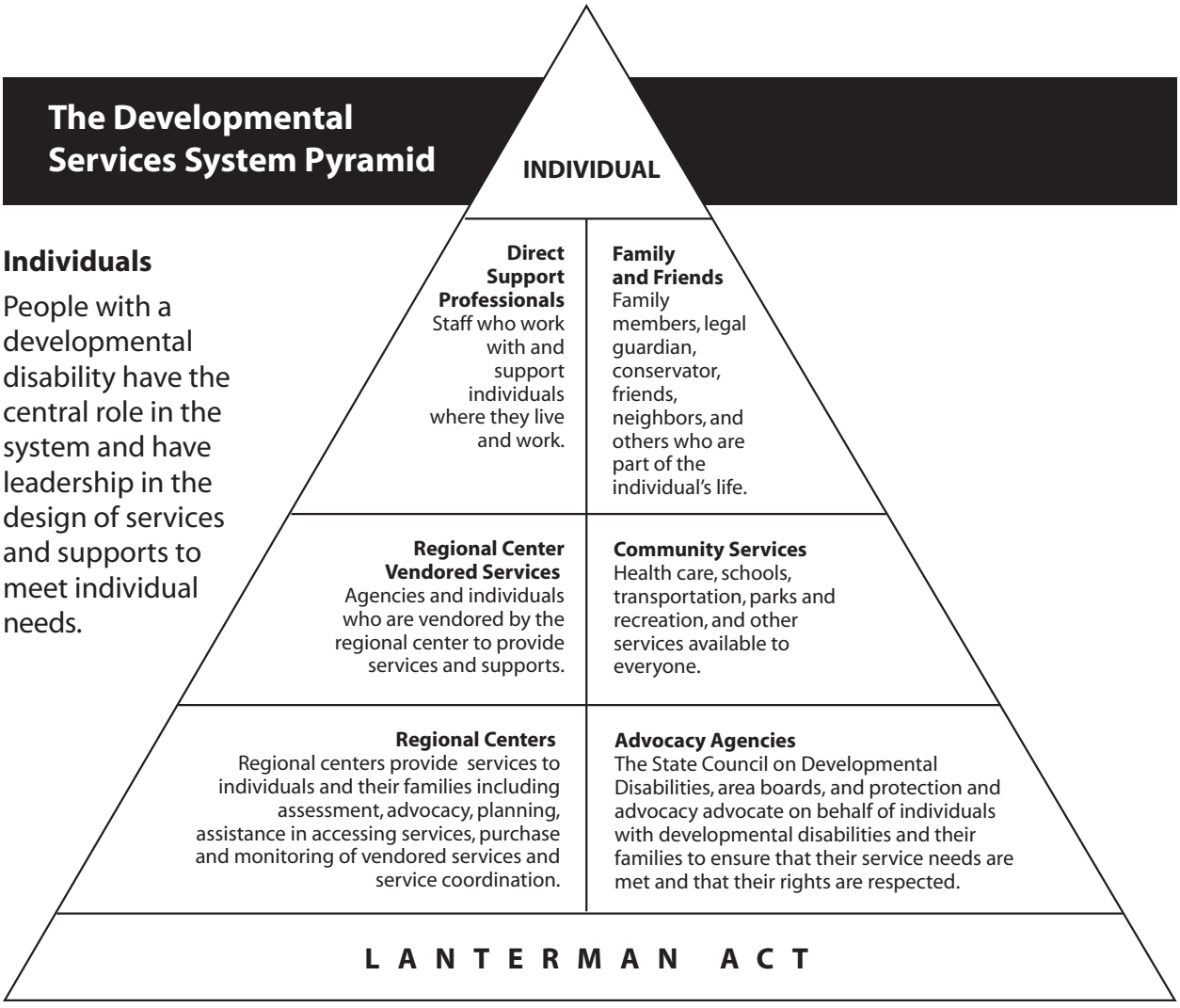
There is a whole network of people and agencies that are working to support individuals and their families in addition to DSPs. These agencies and individuals make up the developmental disabilities service system in California, and all have a common goal of ensuring quality services to support individuals to have healthy, safe, and fulfilling lives.

It is helpful to think about this system of services as a pyramid with the Lanterman Act as the foundation and various levels of support for the individual building upon that foundation.

The Developmental Services System Pyramid

Individuals

People with a developmental disability have the central role in the system and have leadership in the design of services and supports to meet individual needs.



Department of Social Services, Community Care Licensing

As a DSP working in a community care facility, you also need to know about Community Care Licensing (CCL). The Department of Social Services is a state agency that licenses homes for children, adults, and the elderly through its Community Care Licensing Division. The Department of Social Services writes regulations or rules for community care licensed facilities. These regulations are typically referred to as **Title 22**. Community Care Licensing has a responsibility to monitor homes to ensure that they follow the licensing regulations. You need to be familiar with Title 22 because it explains how you do your job. (Information about how to get a copy of Title 22 is included in Appendix 2-B.)

Community Care Licensing has a responsibility to ensure that community care facilities are following the requirements contained in Title 22. Community Care Licensing facility evaluators visit homes on at least a yearly basis to make sure that services are being provided as required in Title 22.

The Individual Program Plan

The Lanterman Act says that each eligible individual must have an **Individual Program Plan (IPP)**. The IPP is a written agreement between the individual and the regional center that lists the individual's goals and the services and supports needed to reach those goals. The IPP is developed by the planning team based upon the individual's needs and preferences.

Once the IPP is developed, the service coordinator works with individuals and the planning team to locate and coordinate needed services and supports.

The IPP is developed through a process of **person-centered planning**. This means that the individual with the developmental disability is the most important person on the **planning team** and that his or her needs, preferences, and choices are the focus of the planning effort.

The IPP contains goals, objectives, and plans. **Goals** describe things that the individual wants in his or her future. Objectives set a time frame for achieving the goals. Plans are the steps to achieve the goal. Plans say who will do what and by when. As a DSP, you are often responsible for providing services and supports to assist the individual to achieve his or her IPP goals.

IPPs also contain a review date, an agreed-upon time (but no less than yearly) when goals, objectives, and plans will be looked at by the planning team for what is working and what is not working for the individual and to determine progress towards goals.

At least once every three months, the service coordinator will visit the individual, usually at his or her home, to talk to the individual and to monitor the implementation of the IPP.

The regional center must provide information that supports individuals as they make choices about the services and supports they need and, once needed services and supports are agreed upon, help find the services the individual needs.

The DSP's role is to make sure these services are provided to the individual and to follow the directions in the IPP about how to support the individual to meet his or her daily needs.

You may also assist the individual to get ready for his or her IPP meeting. You can do this by talking to the individual about what he wants in his life, his hopes and dreams, and by encouraging him to share his thoughts with the planning team.

ACTIVITY

The IPP

Directions: Think about an individual you work with. With a partner, take turns asking each other the following questions about him or her. If there are questions you couldn't answer, go back to the home where you work, read the individual's IPP and try to find the answers.

1. Where is the individual's IPP located?
2. What does that IPP require you and other staff in the home do for the individual?
3. How do you know, or learn about, his/her likes and dislikes?
4. Name some of his/her likes or dislikes.
5. How do you make sure that the services you provide meet his/her needs and preferences?
6. How do you know when the needs or preferences of the individual change?
7. What do you do when you observe such a change?
8. What kinds of input are you asked to give when it is time to develop or amend the individual's IPP?

Individual Rights

The Lanterman Act says that individuals with developmental disabilities have the same **rights** as everyone else. The Lanterman Act says that individuals have:

A right to services and supports to help them live the most independent productive life possible.

DSPs and others must support individuals to meet their goals in the following areas:

- Where to live.
- Where to go to school.
- Where to work.
- How to become involved in community activities.
- Who to live and have relationships with.
- What services and supports the individual wants and needs.

A right to dignity and humane care.

The DSP must treat individuals with kindness and respect and as valuable and important. The DSP must work to ensure that the individual has a safe and comfortable place to live, healthy and appealing food to eat, and a caring environment with a right to privacy. The DSP must respect the individual's privacy in all areas including:

- Personal care.
- Mail and telephone conversations.
- Time to be with family or friends.
- Personal (alone) time.
- Personal space (in the individual's room).
- Personal possessions.
- Sexual expression.

In addition, the DSP must not share personal information about an individual except as required as a part of your job. Information about the individual is confidential. **Confidential** means that you:

- *Do not* discuss information about individuals with your friends.
- *Do not* take individuals' records out of the home.
- *Do not* give information to persons who might ask for it without a signed consent from the individual or legally authorized representative.
- *Do not* discuss confidential information with another individual living in the facility.

A right to participate in an appropriate program of public education.

Public schools must provide an education to individuals younger than 22 years of age. For children of school age, DSPs must work with local schools to support each child's educational program.

A right to prompt medical care and treatment.

Staying as healthy as possible is important for everyone. People should have access to care to achieve the best possible health. The DSP's role is to help individuals get medical, mental health, and dental care and treatment. This means knowing about each person's health care needs, helping to find a good doctor, preparing for a doctor's visit, getting to the doctor, maintaining medical insurance and getting emergency medical help when necessary.

A right to religious freedom and practice.

Many individuals belong to religious communities, be that a church, temple, mosque, or other meeting place, to be with people who believe the same things and worship the same way. The DSP's role is to support the individual by helping them with transportation or whatever else may be necessary to enable the individual to practice his or her beliefs. Individuals who are developmentally disabled have the right to believe what they want about religion or faith. The DSP cannot:

- Tell the individual what to believe.
- Punish the individual for what he or she believes.
- Stop the individual from becoming a member of or practicing a religion of his or her choice.

A right to social interaction and participation in community activities.

Everyone likes to have friends and to do fun things with their friends. The DSP's role is to support individuals to:

- Choose the people they spend time with.
- Spend time with people they like and who like them.
- Choose where they want to go in their free time.
- Go to places where they can work, take care of personal business, buy things, help other people, learn things, and meet and be with other people.

A right to physical exercise and recreation.

Exercise helps individuals keep their bodies strong and healthy. Walking, biking, running, swimming, and going to the gym are types of physical exercise. Recreational activities help individuals relax and have fun. They may include such activities as playing music, biking, swimming, and dancing. The DSP's role is to assist the individual to get exercise and to do things for fun or relaxation.

A right to be free from harm.

Individuals cannot be secluded or restrained in any way. Individuals should have a chance to learn how to keep themselves safe, or have services and supports that provide safety.

It is wrong to refuse to help individuals who need help to eat, go to the bathroom, or stay clean and well-groomed.

No one is allowed to:

- Hit, push, or hurt an individual in any way.
- Scare an individual.
- Stop an individual from talking or going somewhere important to him or her.
- Give an individual medicine when he or she does not need or want it.
- In any way abuse an individual or neglect his or her care.

If the DSP sees that an individual is abused or neglected, the DSP is mandated to report it. [Mandated reporting will be covered in detail in the next session.]

A right to be free from hazardous procedures.

Doctors and other professionals sometimes do things to figure out why an individual is having problems so they can help them. These "things" are called "procedures." Some procedures may hurt, but they are necessary. Procedures that hurt an individual unnecessarily or harm other parts of his or her body or mind are called "hazardous" procedures. An example of a hazardous procedure is using electric shock to change the individual's behavior.

Individual Rights

A right to get services and supports in the "least restrictive environment."

"Least restrictive environment" means places close to the individual's home community, including places where people without disabilities get services and supports, if that is appropriate. This also means services should be near the individual's home and with people from his or her community.

A right to make choices about:

- Where and with whom they live.
- Relationships with others.
- How they spend their time.
- Goals for the future.
- Services and supports they want and need.

The DSP's role is to support these choices, to ensure opportunities for making choices in the daily lives of individuals, and to respect and honor those choices.

A right to have friends and intimate relationships, marry, be part of a family, and to be a parent if they choose.

The DSP's support may be needed to help people start and keep relationships with friends and other community members. The DSP is also responsible to support individuals in obtaining accurate information about human sexuality to assist individuals in their life choices. Support may be needed to develop intimate relationships (like transportation, family counseling, or training in human development and sexuality). Individuals have a right to sexual expression and to information about—and to choose or refuse—birth control options.

A right to be involved in their community in the same way as their neighbors, friends, and fellow community members.

DSPs must find ways to honor cultural preferences for foods, celebrations of holidays, involvement in organizations, and other activities the individual may choose. DSPs must also support individuals in participating as members of their communities and help to create supportive and welcoming communities.

The Lanterman Act also states that individuals who live in licensed residential facilities have these additional rights:

- To wear their own clothes.
- To keep and use their own personal possessions, including toiletries or other personal care items.
- To keep and be allowed to spend a reasonable sum of their own money.
- To have access to individual storage space for private use.
- To see visitors each day.
- To have reasonable access to telephones, and to make and receive confidential calls.
- To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
- To refuse electroconvulsive therapy.
- To refuse behavior modification techniques that cause pain or trauma.
- To refuse psychosurgery.
- To make choices in areas including, but not limited to, daily living routines, companions, leisure and social activities, and program planning and implementation.
- To have information needed to make an informed choice.

Legally Authorized Representatives

Parents, Guardians, and Conservators

As a DSP, you need to have a basic understanding of the rights and responsibilities of parents and other **legally authorized representatives**. A parent or guardian of a minor (child under the age of 18) or, under certain circumstances, the conservator of an adult (18 years or older) may make decisions for the individual. Some of those decisions may affect the individual's rights.

Competence

Competence (or incompetence) refers to an individual's ability to make decisions. Children (in California, a child is anyone under age 18) are presumed to be incompetent, that is, not able to manage alone to come to reasoned decisions about certain important matters. Upon reaching adulthood (in California, anyone 18 or older), even if the person has a significant intellectual impairment, he or she is presumed to be competent and able to make decisions on his or her own.

Parents

Parents are considered natural guardians of their biological or adopted children (under 18 years of age) and have certain rights and responsibilities in making decisions on behalf of their children.

Some parents incorrectly presume that as parents, their legal responsibilities continue for their adult child with a developmental disability. This is not true unless there has been court action to declare an adult "incompetent."

Guardianship

Some children (under 18) need a court-appointed guardian if parents have died, abandoned a child, or had their parental rights removed by a court of law. The issues surrounding guardianship are few, precisely because the law presumes incompetence. Since 1981, guardianships have only been available for minors.

Conservatorship

A conservatorship is a legal arrangement in which a competent adult oversees the personal care or financial matters of another adult considered incapable of managing alone. There are two kinds of conservatorship:

General Conservatorship

This is the conventional kind of conservatorship for incapacitated adults unable to meet their own needs or manage their own affairs.

Limited Conservatorship

The purpose of limited conservatorship is to protect adults with developmental disabilities from harm or exploitation while allowing for the development of maximum self-reliance. If granted by the court, the limited conservator can have decision making authority (or be denied authority) in as many as seven areas:

- To fix the person's place of residence.
- To access to confidential records and papers.
- To consent or withhold consent to marriage.
- The right to contract.
- The power to give or withhold medical consent.
- Decisions regarding social and sexual contacts and relations.
- Decisions concerning education or training.

Short of a special court order, the limited conservator may not, however, provide substitute consent in the areas of:

- Experimental drug treatment.
- Electroshock therapy.
- Placement in a locked facility.
- Sterilization.

Legally Authorized Representatives (continued)

The limited conservator should have:

- Personal knowledge of the conserved individual.
- Knowledge of what constitutes the "best interest" of the conserved individual.
- A commitment to providing that which is in the person's "best interest."
- Financial management skills (as appropriate).
- A knowledge of programs and services and their availability and effect.
- Knowledge of appropriate methods of protection.
- Proximity to the conserved individual.
- Availability in terms of time and energy.

Denial of Rights

Most individual rights may not be denied for any reason. A few rights may be denied for a limited period of time under a very narrow set of circumstances called the **Denial of Rights Procedure**.

These rights may be denied only when certain conditions are documented, and the denial is approved by the regional center.

Prevention and Problem-Solving Rights "Issues"

The DSP must always be on the alert for possible violations of individual rights. By doing so, DSPs may see:

- Rights issues between individuals where one person's rights infringe on another's.
- Rights issues between individuals and staff.
- Rights issues between individuals and conservators.
- Rights issues between individuals and family members.

All issues that may come up are not necessarily rights issues, but may be perceived as such by the individual. You must:

- Carefully evaluate each situation, talk to those involved, think about what you have observed.

- Talk to other staff to find out what they have seen and heard.
- Talk to your administrator. You may also want to talk to the service coordinator for the individual.

Ultimately, you will have to decide if a rights violation has occurred. Rights violations are "reportable incidents" which will be discussed in the next session.

There are actions that the DSP can and must take to prevent rights violations. When an individual moves to a home, he or she must be given understandable information about his or her rights. A copy of the Lanterman Act rights must be posted in an area where everyone can see it. Regional centers have videos, posters, and other materials that may be helpful. Individuals must also be informed of both internal and external grievance and complaint procedures and be provided with names and phone numbers of advocacy agencies and the Consumer Rights Advocate.

Community Care Licensing requires agreed-upon house rules that reflect the concerns and preferences of the individual living in the home. For example, if staff or an individual living in a home smokes, this should be discussed and rules for smoking agreed upon.

The purpose of house rules is to create an environment where people can live together in harmony and not infringe on each other's rights. Everyone—staff and individuals living in the home—should know what the house rules are and have a written copy.

It is a good idea to have regular meetings that include both staff and individuals living in the home, during which individuals discuss and resolve issues, make decisions regarding household issues (for example, recreational activities, group outings, menus, changes in house rules, and so forth), and discuss rights.

DSPs must be knowledgeable of individual rights, house rules, and both internal and external consumer grievance and complaint procedures and be prepared to support individuals in following these procedures.

Locating and Using Advocacy

A key role of the DSP is to advocate on behalf of individuals and their families to ensure that their service needs are being met, that services are of good quality and that rights are being respected. The Lanterman Act provides for advocacy services for persons with developmental disabilities through the following agencies:

- State Council on Developmental Disabilities and area boards: In California, 13 area boards provide individual advocacy. A DSP may contact them to obtain information on behalf of an individual or assist the individual to advocate for him or herself.
- Protection and Advocacy, Inc. (PAI): PAI is responsible for protecting the rights of individuals. Services include legal counseling and representation for individuals. PAI has Consumer Rights Advocates specially assigned to provide individual advocacy services.

In California, a resource for self-advocacy is People First of California, Inc. People First has chapters throughout California and publishes a newsletter with information about self-advocacy, *People First Star*. People First chapters help individuals learn about their rights and to speak up for themselves.

Advocacy is	***Advocacy is not***
• Helping individuals help themselves.	• Taking over an individual's life.
• Building self-confidence.	• Making an individual dependent.
• Supporting independence.	• Doing everything for an individual.
• Telling individuals their rights.	• Not informing an individual of his/her rights.
• Telling individuals their options.	• Making decisions for individuals.
• Providing assistance and training.	• Controlling individuals.
• Helping locate services.	• Making adults feel like children.
• Asking individuals what they want.	• Limiting options.
• Treating adults like adults.	• Knowing what is best because you are a professional.
	• Not respecting choices.

ACTIVITY

After reading the scenario, list the possible rights issues. You can refer back to the sections on individual rights. Then write down what the DSP can do to advocate for the individual or support the individual in advocating for him or herself.

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SCENARIO #1: CHARLES

Charles is 42 years old and has both developmental and physical disabilities (cerebral palsy, epilepsy). It is difficult to understand him when he talks. He hasn't seen his family in a long time, and it is unknown if he even has family still living. He has a history of wandering away when not watched closely and tends to "borrow" tape recorders and clothing from other individuals living in the home. Charles often has what appears to be a poor appetite, plays with food on his plate, and occasionally throws food. He doesn't like getting up in the morning and has to be repeatedly asked to get out of bed. The DSP in the home makes Charles get up early on weekends because he won't get up on weekdays. He loves to sit outside on weekends and listen to his radio. It is repeatedly taken away for bad behavior and not getting up in the mornings.

When other residents have family or visitors, Charles gets very excited and wants to go with them if they leave the home. Charles often sneaks out of the home right after visitors leave and gets very angry when he is brought back. He is only allowed to leave the facility once a month when the group goes on an outing. He doesn't initiate activities often and only participates with other residents when made to do so. He tends to hang out in the kitchen when meals are being prepared but gets in the way, and the DSP often makes him leave the room until the meal is ready.

Possible rights issues:

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What could the DSP do to advocate for the individual and/or support the individual in advocating for him or herself?

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ACTIVITY

SCENARIO #2: MICHAEL

Michael is 18 years old. He uses a wheelchair and is totally dependent on others for his daily care. He often yells very loudly and is locked in his room and left there as punishment. He has use of his arms and hands, but not enough strength to transfer himself from his wheelchair. He is able to manage his manual wheelchair. He is usually uncooperative with DSPs in daily grooming and bathing. DSPs sometimes comb his hair but forget the other grooming tasks when he is especially uncooperative.

Michael has a very involved family who visits him in his home and takes him to their home on a monthly basis. He says he doesn't want to go, and he is unhappy and grumpy for several days afterward. Michael gets along well with one of the other young men living in the home and often spends hours in his company. He likes to share his personal possessions and often gives them away. He likes to talk on the telephone and spends hours talking to friends. As a result, he often loses his telephone privileges for long periods of time until he promises not to talk so long.

Possible rights issues:

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What could the DSP do to advocate for the individual and/or support the individual in advocating for him or herself?

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ACTIVITY

SCENARIO #3: MARY

Mary is a 34 year old with a history of depression and outbursts (yelling, screaming, cursing, self-abuse, and threats of physical aggression). She also threatens peers at home and in the community. Mary is often kept in her room as punishment for her behavior. She is not allowed to go on outings with the group if she has been threatening peers. It is easier to leave her at home. Mary also has a history of crying and screaming for several hours at night, which keeps staff and other individuals awake. When the DSPs reach their "wit's end," they ignore her and let her cry and scream until she wears herself out and finally goes to sleep.

Mary says she wants to help handicapped children, feel loved, and not be so lonely. She says she is not a baby and feels bad when she is treated like one. She wants to go to church, sing in the church choir, learn how to take care of herself, cook, and do her own laundry. The DSP will not let Mary do any special things because she has such bad behavior. The DSP tells her that when she has better behavior, he will help her learn to do some of the things she wants to do.

Possible rights issues:

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What could the DSP do to advocate for the individual and/or support the individual in advocating for him or herself?

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ACTIVITY

SCENARIO #4: CHARLENE

Charlene is 35 years old. She is very verbal, healthy, and active at home, at work, and in the community. She loves to shop for clothing and go to movies, dancing, and parties, and to help with chores at home. She also likes to collect brochures, newspapers, magazines, and small pieces of paper, which she puts in her dresser drawers. DSPs go into her room periodically and remove her collection, throwing it in the trash because there isn't enough room in her drawers for her clothes anymore.

Charlene knows all the merchants in her neighborhood. She tends to purchase lots of "junk" items, so the DSP keeps her money and makes Charlene wait until she can go with her to the store. Charlene has a male friend, Sam, and wants to have him visit her once in awhile. The administrator of the home has told Charlene that she is not allowed to have male visitors. She has also been told that she cannot go out on a date with Sam or any other male friend.

Possible rights issues:

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What could the DSP do to advocate for the individual and/or support the individual in advocating for him or herself?

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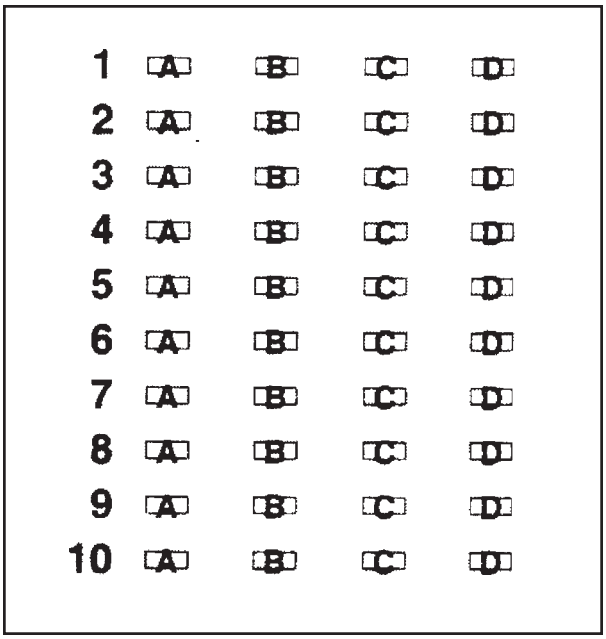
PRACTICE AND SHARE

When you are next in the home where you work, look for a copy of the Lanterman Act Rights. Where is it posted? Ask an individual you work with if she knows about her rights. What rights does she know about? Do you think that she needs more information? If so, do you have some ideas about how to help the individual learn more about her rights? Be ready to share at the beginning of the next session.

The California Developmental Disabilities Service System



1. **The organizations known as Protection and Advocacy, the State Council on Developmental Disabilities, and the Department of Developmental Services:**
   A) Together make up the leadership and staff of each regional center.
   B) Operate along with the regional centers to help make sure individuals get the services they are entitled to under the Lanterman Act.
   C) Each send a representative to participate on each individual's person-centered planning team during the development of the IPP.
   D) Fund all generic services for individuals with developmental disabilities.

2. **One function of the Department of Developmental Services is to:**
   A) Change the Lanterman Act when necessary.
   B) Make up an IPP for each individual receiving services.
   C) Write and revise the Title 17 regulations as needed.
   D) All of the above.

3. **Which of the following is a job the regional center does?**
   A) Makes up and updates the Title 17 regulations as needed.
   B) Pays for the services received by individuals.
   C) Provides Protection and Advocacy services to vendors.
   D) Licenses and operates the Community Care Facilities in its area.

4. **The "IPP" process and document is created:**
   A) By the individual and his or her planning team.
   B) By the regional center in cooperation with the Department of Developmental Services.
   C) By the individual and his or her service provider or residential facility.
   D) In order to make it possible for the individual to use "generic" services.

5. **By law, the IPP planning team includes:**
   A) The individual for whom the planning is being undertaken.
   B) A representative of the licensed home.
   C) The director of the Department of Developmental Services.
   D) A field representative of the local state senator or state assembly member.

6. **An IPP that is developed through the person-centered planning process:**
   A) Contains the goals the DSP decides are best for the individual.
   B) Must include at least one highly experienced DSP on the planning team.
   C) Reflects the needs and preferences of the individual.
   D) Must be sent to the Department of Social Services for approval before it can go into effect.

7. **One responsibility the DSP has in helping individuals exercise their rights is to make sure the individual:**
   A) Gets to vote in every election.
   B) Has opportunities for privacy and time alone.
   C) Has an HIV-free partner for sex during their free time.
   D) Attends church or has other religious activities.

8. **A DSP has a responsibility to make sure each individual:**
   A) Has a special activity to keep them busy during their free time.
   B) Can choose their own friends.
   C) Is punished in a loving, supportive manner when they do not behave correctly.
   D) Has a copy of the Lanterman Act and the Title 17 regulations.

9. **If the DSP sees that an individual is being abused or neglected, the DSP must:**
   A) Immediately do whatever is necessary to stop the abuse or neglect.
   B) Check to make sure the IPP specifically allows the abuse or neglect to occur.
   C) Report the abuse or neglect to the proper authorities.
   D) Make sure the abuse does not include use of electric shock.

10. **California People First is a resource for:**
    A) Individual services and supports that are vendored by the regional center.
    B) Individual self-advocacy to help people learn about their rights and to speak up for themselves.
    C) Legal counseling and representation.
    D) Person centered planning and service coordination.

Appendices

Appendix 2-A

Agencies Supporting Individuals with Developmental Disabilities

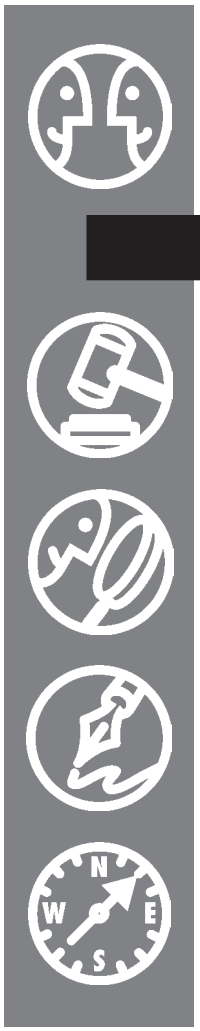
A number of agencies and organizations support individuals with developmental disabilities, such as:

- **Health and Human Services Agency:** The umbrella agency for the Departments of Social Services, Health Services, Developmental Services, Mental Health, and Rehabilitation.
- **Department of Social Services (DSS):** Licenses homes for children and adults with developmental disabilities through its Community Care Licensing Division.
- **Department of Health Services (DHS):** Administers the Medi-Cal program that pays for health care. Also licenses and monitors homes for people with developmental disabilities and significant health needs.
- **Department of Developmental Services (DDS):** Contracts with 21 regional centers to provide services to children and adults with developmental disabilities. DDS is also responsible for managing the state developmental centers.
- **Department of Mental Health (DMH):** Oversees county mental health services.
- **Department of Rehabilitation (DR):** Provides funding for Work Activity Programs (WAPs), which include work support services in sheltered and community-based employment settings.
- **Department of Education (DOE):** Manages education programs in the public school system, including special education services.
- **Special Education Local Plan Area (SELPA):** Local educational service areas throughout the State of California that manage regional educational programs for students with disabilities ages birth through 22 years of age.
- **Local School Districts:** Provide educational services to children with disabilities ages birth through 22 years of age.
- **State Council on Developmental Disabilities (SCDD):** Develops a state plan, which looks at the future of services for individuals with developmental disabilities; reviews and comments on budgets and state agency regulations that provide services to people with developmental disabilities; and funds area boards.
- **Protection and Advocacy, Inc. (PAI):** Protects the civil and service rights of Californians with developmental disabilities through legal advocacy.
- **Area Boards:** Protect the rights of Californians with developmental disabilities through public information and education and by monitoring policies and practices of agencies that are publicly funded.

Appendix 2-B

Laws and Regulations

- **Rehabilitation Act of 1973:** This Act is known as the first federal civil rights law protecting the rights of individuals with disabilities. It prohibits discrimination based on disability in the following areas: (1) education; (2) vocational education; (3) college programs; (4) employment; (5) health, social service programs, welfare; and (6) federally funded programs.
- **The Americans with Disabilities Act (ADA):** Congress passed this law in July of 1990. It is a landmark civil rights bill that protects against discrimination to people with disabilities. It requires modifications, accessibility, and reasonable accommodations; covers state and local governments; and addresses four main areas of potential discrimination: (1) employment; (2) public facilities; (3) transportation; and (4) communication.
- **Individuals with Disabilities Education Act (IDEA):** Guarantees six important rights: (1) free and appropriate public education for all children with disabilities; (2) education in the least restrictive environment; (3) an individualized education program (IEP); (4) provision of necessary related services in order to benefit from special education; (5) fair assessment procedures; and (6) due process and complaint procedures.
- **IDEA, Part C:** Early education opportunities available to infants and toddlers less than 3 years of age who have a low incidence disability or a developmental delay or are at risk of such a delay.
- **Title 17:** Copies of Title 17 may be obtained at a local regional center; by contacting Barclays Law Publishers, 400 Oyster Point Blvd., P.O. Box 3066, South San Francisco, CA 94080 (415) 244-6611; or at the Department of Developmental Services Web site, www.dds.ca.gov.
- **Title 22:** Copies of Title 22 may be obtained at a local licensing office or by contacting Barclays Law Publishers, 400 Oyster Point Blvd., P.O. Box 3066, South San Francisco, CA 94080 (415) 244-6611 or at the Department of Social Services website, www.dss.ca.gov
- **The Lanterman Act:** A copy of the Lanterman Act may be obtained at the Department of Developmental Services website, www.dds.ca.gov.



Student Resource Guide

3. Risk Management & Incident Reporting

Student Resource Guide: SESSION 3

Risk Management and Incident Reporting

OUTCOMES

When you have finished this session you will be able to:

- Identify principles of risk management.
- Identify common risks to individuals' health and safety.
- Identify measures to mitigate risks.
- Describe how to use risk assessment tools.
- Define "mandated reporter."
- Identify incidents that the DSP is required to report.
- Describe procedures for reporting abuse and neglect.
- Complete a special incident report.

KEY WORDS

Incident reporting: By law and regulation, the DSP is required to report certain events to regional centers, Community Care Licensing and/or protective services agencies.

Mandated Reporter: Any person, paid or unpaid, who has assumed full- or part-time responsibility for the care or custody of an elder or dependent adult. DSPs are mandated reporters.

Mitigate: To lessen the effects of risks.

Risk Management: A term given to a set of practices that lead to minimizing possible harm to individuals.

Opening Scenario

Madeline is a 24-year-old woman. When she was 8 years old her mother died of breast cancer, and she sees her father infrequently since he lives in another state. Maddy, as she is called, does not speak but uses gestures and shakes her head for "no" and "yes." Maddy has good skills in many areas. She is artistic and loves to dance. She is very aware of her appearance and takes time to look her best. Maddy is a friendly young woman and is always eager to meet new people. While this is a positive trait, it also has caused some problems; for example, at times she has given her money to strangers.

Maddy had a serious accident when she was younger and is usually very cautious in everything she does. She has a history of seizures, especially when she gets hot. She loves to walk in her neighborhood and rides public transit, but occasionally needs support to remember routes.

Kella, one of the DSPs supporting Maddy and her roommate, has been in this position for two years. Kella believes strongly in facilitating Maddy's independence and supporting her choices, but also worries that Maddy might make some poor choices or put herself in risky situations.

Risk Management—Prevention Is the #1 Priority

The role of the DSP in **risk management** is to actively promote prac tices that will keep individuals safe. Whenever possible, you want to anticipate risks that may exist for individuals and prevent them from happening.

Risk management is something that, even now, you do every day. For example, when you get in a car, you put on your safety belt because you know that this will reasonably reduce your risk of injury or death in case of an accident. The whole purpose of risk management is to anticipate potential risks and develop individualized strategies to reduce the risk. The following principles are basic to your practice of risk management.

1. Prevention of serious incidents is the number one priority.

The best possible risk management strategy is to anticipate risks and prevent them from happening. As a DSP, your first priority is to prevent injury or harm to individuals you support and to protect them from abuse, neglect, and exploitation.

2. Creation and maintenance of safe environments is everyone's responsibility.

We are all responsible for looking out for risks and making environments safer. If you see a rake left where someone could trip over it, put it away. If there is water on the floor that might cause someone to slip, wipe it up. Again, you need to anticipate risks and prevent accidents from happening.

3. Open communication is key to prevention.

Open communication and sharing of information is key to identifying risks and ensuring safety. *Everyone*, the individual, family, and all members of the planning team, including the DSP, may have important information about potential risks and how to address them.

4. All who are required to report incidents, including DSPs, are competent to respond to, report, and document incidents in a timely and accurate manner.

DSPs, as well as regional center staff and others who witness or learn about an incident, must report it accurately and in a timely manner. In this session, you will learn what to report, how to report it, to whom, and by when it must be reported. You will also learn about your responsibilities as a "mandated reporter."

5. Ongoing identification, assessment, and planning for both potential risks and actual occurrences is essential to the development of sound, person-centered strategies to prevent or *mitigate* serious incidents.

Risk management is a never-ending process of identification, assessment planning, and evaluation of results.

6. Safety starts with those who work most closely with individuals receiving support and services.

In your role as a DSP, you work day-to-day, hour-to-hour, minute-to-minute with individuals with developmental disabilities. You see things first and are in a position to anticipate risks early, before an accident or injury occurs. You have a unique responsibility in supporting quality of life for individuals and ensuring their health and safety. **Remember: Prevention is the number one priority!**

Identifying Risk

Risk is a normal part of our lives. Many situations involve a certain amount of risk; for example, deciding whether or not to bring an umbrella in the morning because if it rains, you might get wet. You can't do anything about the weather, but you can anticipate it and protect yourself. In deciding, you could watch the TV weather report, read the paper, or go on the Internet to find out weather predictions for the day. Based on this information, you could decide whether or not you need to carry an umbrella. The fact is, we already practice risk management in our own lives.

Let's talk about the types of risks—including health risks—related to functional abilities, challenging behavior, environmental risks, and lifestyle choices that DSPs may identify in the lives of individuals they support.

Health Risks

If you were told that you had diabetes, you would most likely do everything you could to learn about the disease and its treatment and take whatever steps necessary to minimize the effects or risks associated with it. You would probably check your blood sugar regularly, watch your diet, and follow doctor's orders.

In this example, you identified a health risk and then took actions to mitigate that risk. To "**mitigate**" risk means to lessen its effects. You may not be able to totally prevent a risk, but you can lessen its effects and improve an individual's quality of life. The individual's planning team is always a good resource in planning health-related risk prevention and mitigation strategies to protect the individual.

Daily Living

An individual may be at increased risk related to daily living skills. For example, an individual may be at increased risk because of difficulty swallowing, lack of mobility, inability to transfer, or other functional challenges. Once again, the individual's planning team is a good resource in planning risk prevention and mitigation strategies to protect the individual.

Behavior Challenges

An individual might be at an increased risk because of aggressive behavior where he or she might cause injury to themselves or to others.

Environmental Risks

If you find that your home has faulty electrical wiring, and the circuit breakers are blowing daily, you should get it repaired immediately. If the smoke detector has been disconnected because it sounds every time you cook, you need to reconnect it or relocate it immediately. Icy walks, broken seat belts, lack of handrails, and many other environmental conditions are all opportunities to practice risk management, either by preventing or mitigating the risk.

Risks Resulting from Lifestyle Choices

Risk can be greatly increased or decreased by certain lifestyle choices. High-risk behaviors such as driving in heavy traffic, riding a bicycle without a helmet, or walking alone in unfamiliar neighborhoods after dark are lifestyle choices. Practicing unsafe sex carries a high risk. Alcohol and drug abuse are other examples of lifestyle choices that increase an individual's risk. Once again, risks associated with these activities may be either prevented or mitigated through the application of risk management practices.

Supporting Individuals in the Exercise of Rights and Responsibilities

As a DSP you may sometimes find yourself in a situation where you must balance competing priorities. You have just learned that "Prevention is the Number #1 Priority!" You have also learned that individuals have a right to make choices about their lives. So what do you do when an individual wants to do something that you think is risky? As a DSP, you must find a way to both promote independence and support choices while working to reduce risk and provide for individual safety. This is a challenging task, and one that you should not do alone. Whenever a situation arises where an individual's lifestyle choices (or prospective choices) create risks in his or her life, the planning team for that individual should be enlisted to help resolve the dilemma and develop a plan for you to follow.

Smoking is a good example of a lifestyle choice that creates a risk for the individual. An individual you support wants to start smoking. You know that smoking is associated with increased risk of lung cancer and a host of other illnesses, some life threatening, but you also know that part of your job is to support individual choice. In this situation, while you can assist the individual by providing him or her with information about the risks of smoking, you should seek out the assistance of the planning team for the individual in making his or her decision. Situations such as this include a complex set of issues that are best resolved with the benefit of others' expertise and sharing of points of view.

A decision to smoke creates environmental risks as well. Second-hand smoke creates a health risk for others, and smoking can increase the risk of fire. In this scenario, part of your role will be to make the individual aware of the responsibilities that come with his or her choice; for example, keeping the smoke away from those who do not wish to breathe it and smoking in a way that reduces the risk of fire.

Remember, the role of the DSP in risk management is to ***actively*** promote practices that will keep individuals safe. Whenever possible, you want to anticipate risks that may exist for individuals and prevent them from happening. In the above situation, if the individual chooses to smoke, you will not be able to prevent the risk, but you can work with the individual and his or her planning team to take steps to mitigate, or lessen, risk to the individual (and others). In this way you have followed both priorities—you have supported an individual's choice while reducing the risk of harm.

Risk Assessment and Planning

Once you have identified a risk, the next step is to gather more information about that risk and develop a plan to mitigate the risk. This is called risk assessment and planning.

Risk identification, assessment, and planning are all components of risk management that, as we said previously, you do every day. When something happens and you ask yourself, "What happened?" "Why did it happen?" "Has it happened before?" "How often?" "Who was involved?" "What did others observe or do?" you are doing risk assessment.

When you start to think about the future and how to prevent an incident from happening again, you are doing risk management planning. You might ask "What can I do to prevent it from happening again?" or if it has happened before, "What did I do last time and did it work?" "Who else do I need to get help from?" "Is this something that the planning team needs to help with?" This last question is important, especially for those individuals who are at increased risk because of multiple health problems or who have challenging behaviors that put themselves or others at risk. And lastly, "What is my next step?"

As a DSP, you have continuous opportunities to do risk assessment and develop and implement risk prevention and mitigation strategies to ensure safety.

The purpose of any risk assessment process is to:

- Anticipate and identify potential risks.
- Decide who else needs to be involved in helping to assess the potential risk—often the planning team.
- Learn more about the type and degree of risk(s).
- Develop appropriate interventions to minimize potential harm and injury.

An intervention is a strategy that DSPs use to prevent or mitigate a potential (or real) risk. Sometimes an intervention is as simple as moving the rake, as in the previous example. Other times the plan is more complicated and must be discussed with everyone involved in supporting the individual, as well as written down, or documented. Interventions may involve one or more steps, be immediate, or be implemented over time.

When assessing the degree of risk, DSPs should consider such things as:

- Significant changes in the overall status of the individual.
- Multiple health problems.
- Challenging behaviors that have resulted in injury or pose a threat of injury.
- Change in nutrition status.
- Environmental factors.

Example of Risk Identification, Assessment, and Planning

John has the potential to get lost if he gets into large crowds such as those at fairgrounds or arenas. Staff reports that when John feels stressed, he often bangs his forehead hard enough to cause himself injury. They feel that getting lost would be highly stressful for him. At his last physician visit, the doctor warned that if he bangs his forehead many more times, there is a high probability that he will lose his eyesight.

Identification of Risks

- John has the potential to get lost if he gets into large crowds such as those at fairgrounds or arenas. This causes a great deal of stress for John.
- John bangs his forehead when he is stressed. John will lose his eyesight if he bangs his forehead many more times.

The planning team, including the staff from his home, developed the following **risk mitigation plan:**

1. Over the next four weeks, staff will teach John to use a cell phone so that if he is lost he can call for help.
2. Staff will ensure he takes a cell phone on outings.
3. Staff will maintain one-on-one contact with John at all crowded events.
4. Staff will ensure that he wears his lime green florescent jacket with an information card in his pocket that lists who to notify if he is lost and becomes confused.

Using a Risk Assessment Tool

Identifying, assessing, and planning to prevent and/or mitigate risk often takes a team effort. DSPs, working individually or in teams, may want to use an assessment tool such as the sample Risk Assessment Worksheet provided. On this worksheet the DSP simply lists identified risks and suggestions or plans for minimizing risk. DSPs can use this worksheet as a guide for conducting risk management activities. It will help you to document what you have done and to share with others, including the planning team.

This is a reduced example of the Risk Assessment Worksheet. A full copy follows for use with the activity, and a blank worksheet is in Appendix 3-A.

Risk Assessment Worksheet

Description of Risk*	Plans to Manage Risk

* Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.

The worksheet can be used to used to:

- Identify and describe potential risks.
- Identify information important for the planning team.
- Plan intervention strategies to prevent or mitigate risk.
- Identify the need for an evaluation by a specialist.
- Identify the need for special equipment or structural adaptations.
- Determine what kinds of additional services and supports may be needed.
- Document the plan.
- Monitor the results.

ACTIVITY

Identifying Risks and Planning to Prevent or Mitigate Risk

Directions: Using the following scenario, consider what risks need to be addressed by the DSP. As you listen, consider ways to minimize those risks.

Diego is in his mid-30s and has few skills. He has a great smile and enjoys watching people. He makes it known when he likes something by smiling and squealing in delight. It is just as obvious when he does not like something as he will cry and scream. He can eat without assistance, but cannot take care of his toileting needs by himself. He enjoys walking with staff, but his gait is unsteady when he is tired, and he sometimes trips. Diego also enjoys car rides, especially if a trip includes a stop at the Dairy Queen. He goes to an activity center but is usually bored and spends a lot of time just sitting. His favorite activity at the center is music therapy, and he loves to hit his hand on a table in time to the music and can listen for quite a long time, especially if the music is loud. Diego has asked you to help him plan an outing on the weekend.

You have an idea that he might enjoy a music festival at a local park. These things are usually crowded, the music is loud, and there is usually a lot to eat there.

What problems can we anticipate are potential risks for Diego?

Description of Risk*	Plans to Manage Risk
1. No accessible toilets	1. Check with festival organizers about accessibility of toilets

* Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.

DSP Incident Reporting Requirements

General Reporting Requirements

Even with the most conscientious application of risk management principles, regrettably, incidents do happen. When they happen, the DSP is required by law to report these incidents. Depending upon the type of incident, the DSP will report to different agencies, including regional centers, Community Care Licensing, local law enforcement, Adult and Child Protective Services, and the Ombudsman. The timelines for reporting vary depending upon the type of incident as well.

Each county is required to have offices devoted to Adult and Child Protective Services and Ombudsman activities. The Ombudsman receives reports of abuse for elder and dependent adults living in licensed settings such as community care facilities. Adult and Child Protective Services receive reports of abuse and neglect for dependent adults and children, respectively. Each report is investigated, a determination made, and referrals made to appropriate agencies, including law enforcement.

The actual reports are also called by different names. For example, the incident report that goes to regional centers is called a "Special Incident Report." The report that goes to Community Care Licensing is called the "Unusual Incident/ Injury Report." (Appendix 3-E) In this training, you will use a sample Community Care Licensing form. Even though other agencies may have different forms, the information that is required is generally the same. It is a good idea to ask the local regional center if they have a Special Incident Report form and to use the regional center form when reporting to the regional center. Many regional centers accept the Community Care Licensing form as long as it is complete. In general, incident reports must include:

- The name, address, and telephone number of the facility.
- The date, time, and location of the incident.
- The name(s) and date(s) of birth of the individuals involved in the incident.
- A description of the event or incident.
- If applicable, a description (such as, age, height, weight, occupation, relationship to individual) of the alleged perpetrator of the incident.
- How individual(s) were affected, including any injuries.
- The treatment provided for the individual.
- The name(s) and address(es) of any witness(es) to the incident.
- The actions taken by the vendor (licensee, DSP, the individual or any other agency or individual) in response to the incident.
- The law enforcement, licensing, protective services, and/or other agencies or individuals notified of the incident or involved in the incident.
- If applicable, the family member(s) and/or the individual's authorized representative who has been contacted and informed of the incident.

The responsibility to report lies with the person who observed or has knowledge of the incident, and no supervisor or administrator can stop that person from making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise administrators of reports are permitted and advisable. It is important that you know any internal procedures that may be used where you work.

DSP Incident Reporting Requirements (continued)

DSPs must report incidents under several different sections of law and regulation, each establishing different requirements specific to 1) regional center individuals; 2) individuals living in licensed community care facilities; 3) elderly and dependent adults; and, 4) children. The following charts summarize reporting requirements for each of these groups.

You are required to meet *all* reporting requirements. For example, upon reviewing these charts you will see that there are requirements to report abuse to regional centers, Community Care Licensing, Child Protective Services or local law enforcement (for a child), and the Ombudsman or local law enforcement (for an adult). You must meet *all* reporting requirements. Reporting to one does not absolve you of meeting the requirements of another.

What If You Report Something that Really Didn't Happen?

There is no doubt that reporting can be stressful. You do not want to get anyone in trouble and many times have a very difficult time believing that a person could do such a thing. You may fear reprisal or losing a relationship with another person who has been reported. However, stopping or preventing abuse is what is most important, and you as a DSP have a critical role in that. It is better to report and be wrong, than to have abuse go unchecked.

By law, you are required to report incidents that have been reported to you, that you have observed, or that you may "suspect." Reporting is not just your legal duty, but your ethical responsibility as a professional.

Special Incident Reporting to Regional Centers

All regional center vendors (including community care facilities) and vendor staff (including DSPs) must report special incidents to the regional center as follows:

Special Incident Reporting for Regional Center Vendors and Staff

California Code of Regulations (CCR), Title 17, Section 54327

What Do I Report?

Missing individual.

Suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical and/or chemical restraint.

Suspected neglect including failure to provide medical care for physical or mental health needs; to prevent malnutrition or dehydration; to protect from health and safety hazards; to assist in personal hygiene or provision of food, clothing, or shelter; or to exercise degree of care any reasonable person would exercise.

A serious injury/accident including lacerations requiring sutures or staples; puncture wounds requiring medical treatment beyond First Aid; fractures; dislocations; bites that break the skin and require medical treatment beyond First Aid; internal bleeding requiring medical treatment beyond First Aid; any medication errors; medication reactions that require medical treatment beyond First Aid; or burns that require medical treatment beyond First Aid.

Any unplanned hospitalization due to respiratory illness; seizure-related occurrences; cardiac-related events; internal infections; diabetes; wound/skin care; nutritional deficiencies; or involuntary psychiatric admission.

Death of individual.

Individual is a crime victim including robbery; aggravated assault; larceny; burglary; or rape.

To Whom Do I Report?

The regional center with case management responsibility for the individual and the vendoring regional center, if different.

When and How Do I Report?

Call or fax immediately but no more than *24 hours* after learning of the occurrence

and

Submit a written report within *48 hours* of the occurrence of the incident.

Special Incident Reporting to Community Care Licensing

All Administrators and staff (DSPs) of community care licensed facilities must report special incidents to their licensing agency as follows:

Special Incident Reporting for Licensed Community Care Facilities

California Code of Regulations (CCR), Title 22, Section 80061

What Do I Report?

Death of any individual from any cause.

Any injury to any individual that requires medical treatment.

Any unusual incident or absence (lack of supervision or safety precaution) that threatens the physical or emotional health or safety of any individual.

Any suspected physical or psychological abuse.

Epidemic outbreaks.

Poisonings.

Catastrophes.

Fires or explosions that occur in or on the premises.

To Whom Do I Report?

Report to the local Community Care Licensing agency.

When and How Do I Report?

Call within the agency's next working day during its normal business hours.

A written report shall be submitted within seven days following the occurrence of the event.

Reports of Abuse or Neglect Concerning Children, and Elder and Dependent Adults

As a DSP, you are a **mandated reporter.** By law, you must report all incidents involving elder and dependent adults, and children, for which you have observed or reasonably suspect abuse or neglect. Adults with developmental disabilities are by definition dependent adults. Failure to report incidents involving an elder or dependent adult is a misdemeanor, punishable by not more than six months in jail, by a fine of not more than $1,000, or both. A mandated reporter who willfully fails to report abuse or neglect of an elder or dependent adult is subject to one year imprisonment and/or a $5,000 fine. There are similar penalties for failure to report abuse or neglect of children.

As a mandated reporter, you must report incidents as follows:

Elder and Dependent Adult Abuse Reporting Requirements for Mandated Reporters

Welfare and Institutions Code (WIC) beginning with 15600

What Do I Report?

Physical abuse, such as:
Unusual or recurring scratches; bruises; skin tears; welts; bruises on opposite sides of the body; "wrap-around" bruises. Injuries caused by biting, cutting, pinching, or twisting of limbs; burns; fractures or sprains. Any untreated medical condition. Injuries that are incompatable with the explanation.

Psychological abuse/isolation.

Financial (fiduciary) abuse.

Neglect .

To Whom Do I Report?

The local long-term care Ombudsman
or
The police or sheriff's department

When and How Do I Report?

Call immediately or as soon as practicably possible.
and
Follow-up with a written report within two working days.

Child Abuse Reporting Requirements for Mandated Reporters

California Penal Code Sections 11164–1174.4

What Do I Report?

A physical injury that is inflicted by anyone other than accidental means on a child by another individual.

Sexual abuse, including both sexual assault and sexual exploitation, such as:
Child reports sexual activities to a trusted person; detailed and age-inappropriate understanding of sexual behavior for child's age; child wears torn, stained or bloody underclothing; child is victim of other forms of abuse.

Willful cruelty or unjustifiable punishment.

Cruel or inhuman corporal punishment or injury.

Neglect, including both severe and general neglect, such as:
Child lacking adequate medical or dental care; child always sleepy or hungry; child always dirty or inadequately dressed for the weather; evidence of poor supervision; conditions in home are extremely or persistently unsafe or unsanitary.

Abuse (all of the above) in and out of home care.

To Whom Do I Report?

Local Department of Social Services, Child Protective Services,
and
police or sheriff's department.

When and How Do I Report?

Call immediately or as soon as practicably possible.
and
Follow-up with a written report within two working days.

Identifying An Incident Requiring a Mandated Report

Abusive and neglectful behavior toward another can take many forms or combinations. The DSP can help protect individuals from abuse through:

1. **Observation:** Pay attention to individuals in your care. Many individuals cannot tell you when something is wrong.

2. **Communication:** Talk with individuals and other DSPs daily. Talk with staff from day programs, employment programs, and others.

3. **Documentation:** Write down what you see and hear.

4. **Review:** Think about what you have observed, review what you have written and look for patterns.

5. **Report:** If abuse is observed or suspected, take immediate action necessary to protect the individual and then make the required reports.

DSPs play a critical role in ensuring a safe and dignified life for individuals with disabilities.

Signs of Abuse

Remember your DSP Tool Box skills from Session 1. Your observation skills will be important when looking for signs of suspected abuse. Observation means that you will use all of your senses to identify any changes in or injuries to an individual that may be signs of abuse.

There are several different types of abuse that may occur. These include:

1. Physical abuse
2. Neglect
3. Abandonment
4. Financial abuse
5. Isolation
6. Sexual Abuse

Information on the following pages will help you to identify where abuse might be occurring.

Signs of Abuse

1. Physical Abuse

Signs of physical abuse may be evident in bruising, swelling, broken bones or skin, blistering, or open wounds. Physical abuse may also be hidden. DSPs may become aware of changes in an individual's behavior or affect that can signal a problem of abuse.

Indicators of physical abuse may include:

1. Unusual or recurring scratches, bruises, skin tears, or welts.
2. Bilateral bruising (bruising on opposite sides of the body).
3. "Wrap around" bruises due to binding or too firm a grip around a wrist or neck.
4. Bruises around the breasts or genital area.
5. Infections around the genital area.
6. Injuries caused by biting, cutting, pinching, or twisting of limbs.
7. Burns.
8. Fractures or sprains.
9. Torn, stained, or bloody underclothing.
10. Any untreated medical condition.
11. Signs of excessive drugging.
12. Injuries that are incompatible with explanations.
13. Intense fearful reactions to people in general or to certain individuals in particular.

Welfare and Institutions Code Section 15510.63 adds the following reportable situation:

"…use of physical or chemical restraint or psychotropic medication under any of the following conditions:

14. For punishment;
15. For a period beyond that for which the medication was ordered pursuant to instructions of a physician and surgeon licensed in the State of California, who is providing medical care to (an) elder or dependent adult at the time instructions are given; or
16. For any purpose not authorized by the physician or surgeon."

Indicators or descriptions are not necessarily proof of abuse, but they may be clues that a problem exists or that a trend is developing.

2. Neglect

Neglect can be more difficult to recognize at times. It might be helpful to consider the "reasonable person" standard in identifying occasions of neglect. How would a reasonable person in the same situation act?

Neglect is defined in the following way: **the negligent failure of any person having the care or custody of a child, an elder, or a dependent adult to exercise that degree of care that a reasonable person in a like situation would exercise.**

Some examples of neglect are:

1. Failure to assist in personal hygiene or in the provision of food, clothing, or shelter.
2. Failure to provide medical care for physical and mental health needs.
3. Failure to protect from health and safety hazards.
4. Failure to prevent malnutrition or dehydration.

Signs of Abuse (continued)

5. Failure of a person to provide the needs for themselves due to ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health.

Example:

Arthur has a chronic ear infection. He complains that his ear hurts, and there is obvious drainage from the ear. Staff at his work program have contacted his home to ask that he see a physician. There is no response from his care provider and two weeks later, Arthur is still complaining about his ear. The failure of his care provider to get medical treatment for Arthur may be a case of neglect and should be reported.

3. Abandonment

We sometimes hear about abandonment in the news when an infant or a child is found apparently abandoned by his parents. In some cases, this might involve a newborn baby whose mother cannot care for her baby, or it might involve parents who believe they can no longer care for their child. Children left alone for long periods of time while their parents go away are also examples of abandonment. The critical point is that individuals in dependent situations are left without the care they require. In the same way the reasonable person standard was used in discussing neglect, Welfare and Institutions Code Section 15610.05 defines abandonment **"as the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody."**

Examples of abandonment may include:

- Returning home from an outing to find an individual has wandered away and is not present.
- Locking an individual out of a facility as punishment for breaking curfew.
- Refusing to allow an individual to return to a facility without having followed required legal procedures for removal or relocating an individual.

Example:

Roxanne, 29 years old, has been leaving her home late at night after staff go to bed. She is visiting her boyfriend and knows that staff do not want her to go. She typically returns after an hour or so. Marie, one of the DSPs, decides that the next time she finds Roxanne gone, she is going to lock the door and let her stay out all night to teach her a lesson. Of course, this is an example of abandonment, and a care provider legally cannot do this. Roxanne's behavior can be addressed in other, more effective and positive ways.

4. Financial Abuse

Dependent adults may also be the victims of financial abuse. As individuals become less able to be responsible for their finances, they are at risk of being taken advantage of. We often hear about con artists that prey on elders, gaining their confidence and then taking their money. Individuals with disabilities also depend on others to help them manage their finances and are vulnerable to financial abuse.

Financial abuse occurs when a person or entity does any of the following:

- Takes, appropriates, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
- Assists in taking, secreting, appropriating, or retaining real or personal property of an elder or dependent adult for a wrongful use, to defraud, or both.

Some signs that indicate an individual has been a victim of financial abuse may include:

- Disappearance of papers, checkbooks, or legal documents.
- Staff assisting individuals with credit card purchases or ATM withdrawals.
- Lack of amenities: appropriate clothing, grooming items, and so forth.
- Unpaid bills despite availability of adequate financial resources.
- Provision of services that are not necessary or requested.
- Unusual activity in bank accounts, such as withdrawals from automated teller machines when the individual cannot get to the bank.
- Denial of necessary and/or needed services by the person controlling the elder or dependent adult's resources.
- Use of "representative payee" under suspicious circumstances.
- Use of power of attorney or conservatorship when not indicated by certain circumstances.

Example:

Tom is a DSP supporting John at his home. Tom and John have become very close, and Tom assists John with his bill paying, purchases, and banking. Tom is a little short this month, and because he knows that John has some extra money in his account, Tom asks John if he can borrow his ATM card so he can get cash to pay for some incidentals. Because John likes Tom and wants to please him, he gives Tom the card. Tom is abusing his responsibility to John and is using his friendship and influence to his financial gain and is financially abusing John.

5. Isolation

One of the critical roles for DSPs is to encourage and facilitate individuals' friendships and social interactions with peers and other community members. Individuals with disabilities often have difficulty meeting new people and maintaining relationships because of a number of factors, including limited community mobility and skill deficits in communication and social interaction. It is also critical to support individuals in maintaining family ties.

One of the difficulties DSPs report is their discomfort in some of the relationships individuals choose to make and maintain. As a DSP, we might not approve of some of the people the individuals we support choose to spend time with, but we cannot prevent social relationships. As a support provider, a DSP can provide advice and inform, but cannot make decisions about others an adult will see.

There have also been occasions when support providers, as part of a behavior management strategy, have controlled access to others as a reward or punishment. As well meaning as this might be, it is neither allowable nor even a good behavioral intervention. We all have a need for friendship, companionship, and love regardless of how much of a problem our behavior is for others. More effective positive behavioral support strategies are discussed in Session 11.

Isolation means any of the following:

- Acts that are intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.
- Telling a caller or prospective visitor that an elder or dependent adult is not

Signs of Abuse (continued)

present, does not wish to talk with the caller, or does not wish to meet with the visitor when the statement is false and contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

- False imprisonment, as defined in Section 236 of the Penal Code.
- Physical restraint of an elder or dependent adult for the purpose of preventing the elder or dependent adult from meeting with visitors.

There is an exception, however: if the above acts are the instructions of a licensed physician or surgeon as part of the individual's medical care, or if they are performed in response to a reasonably perceived threat of danger to property or physical safety (Welfare and Institutions Code Section 15610.43).

Restraint and seclusion or isolation are prohibited in community care facilities. Restraint is an emergency management strategy, used as a last resort by DSPs trained in such techniques when health and safety are in immediate danger.

Example:

Veronica has been having a very bad week. She is very angry about something and has been striking out at staff and her roommates. Veronica normally goes to her parents' home every other weekend and looks forward to these visits, as do her parents. Ted, a DSP at Veronica's home has decided that Veronica is demonstrating that she is not ready to go home and has taken this privilege away. Veronica is to stay in her room over the weekend, and if she can show better behavior, she can go to visit her parents in two weeks.

Veronica's visit to her parents' home is not a privilege, it's a right. Ted is isolating Veronica in an attempt to change her behavior.

6. Sexual Abuse

Sexual abuse includes a wide range of sexual activities that are forced upon someone. Individuals with developmental disabilities are at an increased risk because of a sense of social powerlessness. They may have significant communication skill deficits that make it difficult to inform others about what is happening to them. Their judgment may be impaired to such a degree that they put themselves in harmful situations or associate with people who are harmful. In addition, many individuals with disabilities have small social circles, and the isolation they feel may make them more likely to associate with people who pay attention to them. Finally, individuals with disabilities often live with roommates and in dependent situations. This makes them more vulnerable to people who they perceive are more powerful.

When abuse is occurring, individuals are often unable to stop it due to a lack of understanding of what is happening, the extreme pressure to go along out of fear, a need for acceptance from the abuser, having a dependent relationship with the abuser, and the inability or unwillingness to question others they perceive to be in authority.

The research on sexual abuse is startling.

- More than 90 percent of individuals with developmental disabilities will experience sexual abuse at some point in their lives (Schwartz, 1991).
- Victims who have some level of intellectual impairment are at the highest risk of abuse (Sobsey & Doe, 1991).

Signs of Abuse (continued)

- Forty-nine percent of individuals with disabilities will experience 10 or more abusive incidents (Valenti-Hein & Schwartz, 1991).
- Each year in the United States, 15,000 to 19,000 individuals with developmental disabilities are raped (Sobsey & Doe, 1991).

There are a number of ways that sexual abuse occurs. What may appear on the surface to be harmless may be abusive, especially if it is unwanted and makes an individual uncomfortable. Sexual abuse may consist of inappropriate and non-consensual actions such as:

- Exposure to sexual materials such as pornography.
- The use of inappropriate sexual remarks and language.
- Not respecting the privacy of a child or other individual.
- Exhibitionism.

or such explicit acts such as:

- Fondling.
- Oral sex.
- Forced sexual intercourse.

How would we know that sexual abuse is occurring?

There are obvious indications of sexual abuse, including unexplained pregnancy and sexually transmitted diseases (STDs). Unfortunately, these conditions are sometimes the first sign of abuse that is noticed. Obviously, there are other signs that can indicate sexual abuse and can move families and staff to intervene. Bruising around the genital area is an obvious signal, as is bruising of breasts or buttocks. Genital discomfort can be an indicator and in any event should be cause for medical attention. Torn or missing clothing may also indicate sexual abuse. More often, however, DSPs may see other, more subtle signs that something serious is going on. There are a number of signals that support providers need to be aware of. Sometimes an individual who is being sexually abused may show physiological symptoms such as:

- Sleep disturbances
- Eating disorders
- Headaches
- Seizure activity

At times, or in addition to physiological symptoms, an individual may show psychological symptoms such as:

- Substance abuse
- Withdrawal
- Atypical attachment
- Avoidance of specific settings
- Avoidance of certain people
- Excessive crying spells
- Regression
- Poor self-esteem
- Non-compliance
- Self-destructive behavior
- Inability to focus or concentrate
- Resistance to physical examination
- Sexually inappropriate behavior

Adapted from *Violence and Abuse in the Lives of People with Disabilities* (1994). Sobsey, D.

ACTIVITY

Identifying Types of Abuse

Directions: Read the scenarios and decide:

- **Does this meet the criteria for abuse?**
- **What type of abuse does it represent?**
- **What steps should be taken?**

---

1. Annette, who is 27, returns from her day program with her blouse ripped. She informs you that someone on the bus was trying to be fresh.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

---

2. Ron, 33 years old, has been talking about getting married to someone he met at the movies. He wants to call her up frequently and invite her over to stay with him in his room. Some of the staff members know this woman and do not want him to see her, and they refuse to let him call her from home.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

---

3. Roxanne, a DSP at the Mary's Care Home has discovered that Yolanda, who is 19, has been having sex with her boyfriend at his home.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

ACTIVITY

Identifying Types of Abuse *continued*

4. Henry, in a fit of anger, struck one of the DSPs and the care home owner. He ran out of the house and still hadn't returned by 10:00 p.m. He has done this on several different occasions, only to return in the early hours of the morning and wake up everyone in the home. The staff decided to lock the door and teach Henry a lesson this time.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

5. Dean enjoys going to the mall. Since he is not independent and still needs some support, a DSP always goes with him and sometimes brings one or two other individuals. Dean leaves the group and goes to a movie. When the others are ready to leave, Dean is not with them, so they go home, figuring that he'll call when he finds them gone.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

6. Rachel, 12 years old, occasionally wets herself. When she does this, she laughs as she wets. Staff know that she can go to the bathroom by herself and believe she does this to be funny. Tim, one of the DSPs, has had enough and swats her on the backside, tells her "No," then sends her to her room.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

ACTIVITY

Identifying Types of Abuse *continued*

7. Robert has asked Cathy, a DSP, to buy him a pack of cigarettes when she is at the store. He gives her $5. Cathy gets the cigarettes and also uses the change to get herself an ice cream cone for her trouble.

Does this meet the criteria for abuse? ☐ Yes ☐ No

What type of abuse does it represent?

. . . . . .

What steps should be taken?

. . . . . .

. . . . . .

ACTIVITY

Reporting Incidents

Directions: Read the following scenarios and answer the questions:

- **Do I need to make a report?**
- **To whom should I report?**

---

1. Little Joey, age 9, just ran outside and heaved his shoes onto the neighbor's roof for the third time this week. Mr. Smith, the neighbor, came running out and yelled, "I am going to call the cops if you people can't control those kids, and I'm keeping these shoes!"

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

---

2. You are walking with an individual along a sidewalk. Just as you notice that his shoe is untied, he steps on the lace and falls to the concrete hitting his head. He gets up quickly saying he is fine. There is no blood or cuts.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

---

3. A resident of a group home, Mr. Johnson, has been in the hospital for a week due to a long illness. He dies while there. He was 78 years old.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

---

4. While assisting Frank with his bath, you discover that he has head lice. You immediately purchase a bottle of Qwell and treat him.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

ACTIVITY

Reporting Incidents *continued*

5. After a fight with her roommate, Mary runs out of the house into the street. She is screaming that she is going to kill herself. Traffic manages to miss her, and you succeed in taking her back into the house after five minutes. She has made similar statements in the past.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

6. You walk into Sam's apartment just in time to hear another staff say, "I told you that if your room was not clean, you couldn't visit your sister this weekend." This is not part of any behavior plan.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

7. While on a ski trip with his parents, Mike breaks his arm and requires surgery to repair it.

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

8. Bob, a very independent fellow, has spent the day at the mall. He left with $20 and now has no money and nothing to show for it. When asked where his money went, he says, "I gave it to a guy who didn't have any."

Do I need to make a report? ☐ Yes ☐ No

Who should I report to?

. . . . . .

. . . . . .

ACTIVITY

Completing a Special Incident Report

Directions: Read the following scenario and write down why a Special Incident Report should be filed. Then, complete the report using the form provided.

On April 5, 2003 at 3:00 p.m., Jose, another individual who is Maddy's friend, came running to you and said, "Maddy is not the same. Something's wrong!" Jose cannot elaborate but is very agitated. You accompany him to Maddy's room. The door is open, but you knock and ask if you can come in. Maddy is sitting on her bed, but does not respond. She appears to have been crying. You ask if she is alright, and she furiously shakes her head "no." You ask Jose to let you and Maddy have some privacy. He goes to his room still very concerned about his friend.

Knowing that Maddy has limited verbal skills, you begin to gently ask questions: "Are you in pain?" "Are you hurt?" "Did something happen to you?" "Did you go out?" "Show me what is wrong." Using this method, you learn that Maddy went for a walk after lunch and that a person in the neighborhood grabbed her by the wrist, which has wrap-around bruising, and tried to push her into a house. She screamed, and the person let her go and went into the house. Maddy ran home and has been crying in her room ever since. She is upset, shaking, and very nervous. You are unable to calm her down.

You tell Maddy that you will bring the administrator to speak with her and that you will make sure this never happens again. You report to the administrator who is very concerned and immediately goes to Maddy. The administrator looks to see if there are other obvious bruises or other injuries and again questions Maddy about the incident.

Why does this warrant a Special Incident Report?

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS : NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER
		( )
ADDRESS	CITY, STATE, ZIP	

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

TYPE OF INCIDENT

- ☐ Unauthorized Absence
- ☐ Aggressive Act/Self
- ☐ Aggressive Act/Another Client
- ☐ Aggressive Act/Staff
- ☐ Aggressive Act/Family, Visitors
- ☐ Alleged Violation of Rights

Alleged Client Abuse

- ☐ Sexual
- ☐ Physical
- ☐ Psychological
- ☐ Financial
- ☐ Neglect

- ☐ Rape
- ☐ Pregnancy
- ☐ Suicide Attempt
- ☐ Other

- ☐ Injury-Accident
- ☐ Injury-Unknown Origin
- ☐ Injury-From another Client
- ☐ Injury-From behavior episode
- ☐ Epidemic Outbreak
- ☐ Hospitalization

- ☐ Medical Emergency
- ☐ Other Sexual Incident
- ☐ Theft
- ☐ Fire
- ☐ Property Damage
- ☐ Other *(explain)*

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES:

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

LIC 624 (4/99)

OVER

MEDICAL TREATMENT NECESSARY? ☐ YES ☐ NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED:

ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

	NAME AND TITLE	DATE
REPORT SUBMITTED BY:		
REPORT REVIEWED/APPROVED BY:		

AGENCIES/INDIVIDUALS NOTIFIED *(SPECIFY NAME AND TELEPHONE NUMBER)*

☐ LICENSING_____ ☐ ADULT/CHILD PROTECTIVE SERVICES_____

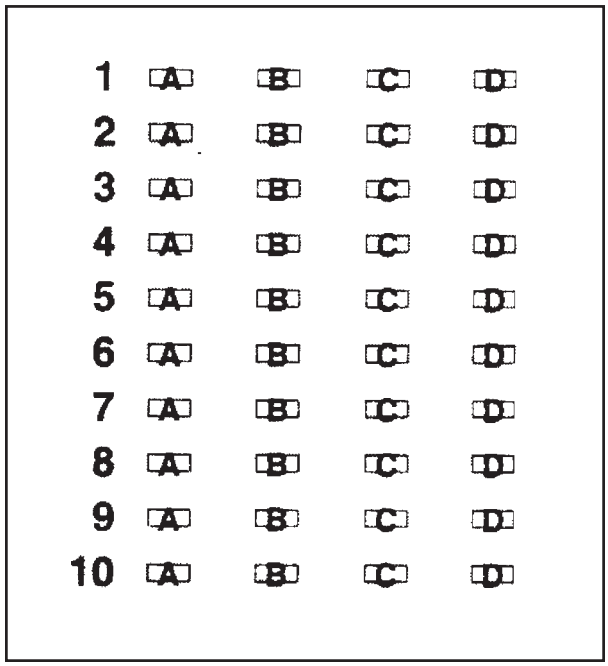
☐ LONG TERM CARE OMBUDSMAN_____ ☐ PARENT/GUARDIAN/CONSERVATOR_____

☐ LAW ENFORCEMENT_____ ☐ PLACEMENT AGENCY_____

PRACTICE AND SHARE

Think about an individual that you support and identify a risk to his or her health or safety. For example, if an individual's mother had breast cancer, she is at risk to develop breast cancer too. Once you identify a risk, think about actions that you can take to mitigate, or lessen the effects of that risk. In the above example, you could consult with the individual's doctor at her next appointment, and ensure that she receives regular exams and screenings for breast cancer. Be prepared to discuss the risk and ideas for mitigating it at the beginning of Session 4.

Risk Management



1. **The most basic principle of "Risk Management" is:**
   A) Do not wait for individuals to be injured before offering them first aid.
   B) Prevention is the Number One Priority.
   C) Wipe up spills if individuals have slipped on them.
   D) Let family members know when individuals get badly injured.

2. **The DSP has an especially important role in effective risk management because:**
   A) The DSP is the only person able to remove danger from individuals' lives.
   B) The DSP works to help people enjoy their lives more.
   C) Person-centered planning is important in reducing risks.
   D) The DSP is often the first person to be aware of risks.

3. **An example of a Daily Living Skills risk would be:**
   A) Electrical power and water service loss.
   B) Difficulty in swallowing or mobility.
   C) Alcohol and drug abuse.
   D) Self-injurious behavior.

4. **The first step in risk assessment and planning work is to:**
   A) Think about what can happen in the future.
   B) Decide how dangerous the risk is compared to other risks.
   C) Identify exactly what the risk is.
   D) Get help from the planning team.

5. **A Risk Assessment Worksheet identifies risks and includes:**
   A) The names of all people working or visiting at the facility.
   B) Plans for minimizing these risks.
   C) Prescriptions and other medical needs for each individual.
   D) Photographs and other documentation of injury and abuse.

6. **A "Special Incident Report" must be filed with the regional center whenever:**
   A) First aid must be given to an individual for a minor injury.
   B) An individual is gone from the home for no known reason.
   C) A meal is served more than 15 minutes after the scheduled time.
   D) The DSP fails to inform the home in advance that they will be unable to come to work.

7. After a "special incident" is reported by phone or fax to the regional center:

A) A written report must be submitted to the regional center within the next two days.
B) The DSP should receive a written acknowledgment of the report.
C) The DSP should write down the time of the call and the name of the person at the regional center who answered the phone.
D) A written report must be submitted to the local police within 72 hours.

8. A "Special Incident Report" is required whenever there is:

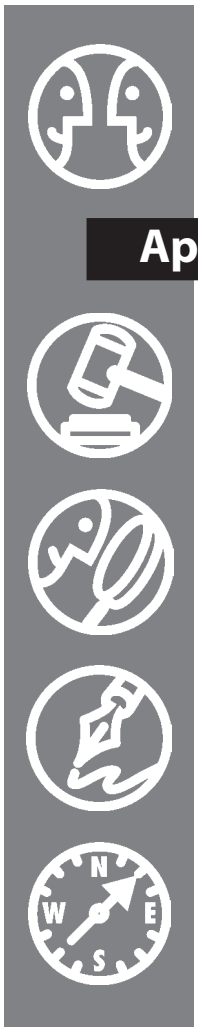
A) A celebration or party involving more than 20 participants.
B) Death of an individual regardless of the cause.
C) Death of an individual, but only if the cause is "suspicious"
D) Every time there is an exchange of bodily fluids between people.

9. Which of the following must be reported by a "mandated reporter"?

A) An individual's expensive clothing is ruined by a defective washing machine.
B) An individual shows signs of having been physically abused.
C) An individual refuses to eat food that they do not think is seasoned well.
D) An individual is unhappy because they are too sick to go bowling.

10. A mandated reporter must report incidents of abuse to:

A) Regional Center and Local Radio or TV Station.
B) Ombudsman or Police/Sheriff.
C) Facility Administrator and 911.
D) All of the above.



Appendices

Appendix 3-A

RISK ASSESSMENT WORKSHEET

NAME:

Description of Risk*	Plans to Manage Risk

* Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.

Appendix 3-B

Term Care Ombudsman Program Contacts (by County)

County	*Center*	*Phone*
Alameda	Ombudsman, Inc.	(510) 638-6878
Alpine	Mother Lode Ombudsman Program	(209) 532-7632
Amador	Mother Lode Ombudsman Program	(209) 532-7632
Butte	Ombudsman Program	(530) 898-5923 (800) 822-0109
Calaveras	Mother Lode Ombudsman Program	(209) 532-7632
Colusa	Ombudsman Program	(530) 898-5923 (800) 822-0109
Contra Costa	Ombudsman Services of Contra Costa, Inc.	(925) 685-2070
Del Norte	LTC Ombudsman Program	(707) 443-9747
El Dorado	El Dorado County LTC Ombudsman Program	(530) 621-6157
Fresno	Fresno-Madera Ombudsman Program	(559) 224-9177
Glenn	Ombudsman Program	(530) 898-5923 (800) 822-0109
Humboldt	LTC Ombudsman Program	(707) 443-9747
Imperial	Ombudsman Program	(760) 336-3996
Inyo	Ombudsman/Advocacy Services	(760) 872-4128
Kern	Ombudsman Program	(661) 323-7884 Only (661) area: (800) 292-4252
Kings	LTC Ombudsman Program	(559) 583-0333
Lake	Nursing Home Ombudsman Program	(707) 468-5882 Only (707) area: (800) 997-3675
Lassen	Northern CA Ombudsman Program	(530) 223-6191
Los Angeles	LTC Ombudsman Program	(310) 393-3618 (800) 334-9473
	Region I - Santa Monica	(310) 899-1483
	Region II - Los Angeles	(213) 617-8957
	Region III - Reseda	(818) 881-6460
	Region IV - Arcadia	(626) 294-9123
	Region V - Lakewood	(562) 925-7104
	Region VI - San Dimas	(909) 394-0416
	Region VII - Lancaster	(661) 945-5563
	Region VIII - Downey	(562) 869-6500
	Region IX - Burbank	(818) 563-1957
Madera	Fresno-Madera Ombudsman Program	(559) 224-9177

County	*Center*	*Phone*
Marin	County of Marin Ombudsman Program	(415) 499-7446
Mariposa	Mother Lode Ombudsman Program	(209) 532-7632
Mendocino	Nursing Home Ombudsman Program	(707) 468-5882 Only (707) area: (800) 997-3675
Merced	Merced County Ombudsman	(209) 385-7402
Modoc	Northern CA Ombudsman Program	(530) 223-6191
Mono	Ombudsman/Advocacy Services	(760) 872-4128
Monterey	Monterey County Ombudsman, Inc. Salinas	(831) 333-1300 (831) 758-4011
Napa	Ombudsman Program	(707) 255-4236
Nevada	Ombudsman Services of Northern California	(916) 376-8910 (530) 274-2825
Orange	LTC Ombudsman Program	(714) 479-0107 Only (562) and (949) areas: (800) 300-6222
Placer	Ombudsman Services of Northern California	(916) 376-8910 (916) 823-8422
Plumas	Ombudsman Program	(530) 898-5923 (800) 822-0109
Riverside	LTC Ombudsman Program	(909) 686-4402 (800) 464-1123
Sacramento	Ombudsman Services of Northern California	(916) 376-8910
San Benito	Ombudsman/Advocacy, Inc.	(831) 429-1913
San Bernardino	LTC Ombudsman Program	(909) 891-3928 (866) 229-0284
San Diego	LTC Ombudsman Program	(858) 560-2507 Only (858) area: (800) 640-4661
San Francisco	Ombudsman Program	(415) 751-9788
San Joaquin	Ombudsman Program	(209) 468-3785
San Luis Obispo	LTC Ombudsman Services of SLO County	(805) 772-3059
San Mateo	Ombudsman Program of San Mateo, Inc.	(650) 742-9131 Only (650) area: (800) 674-8437
Santa Barbara	LTC Ombudsman Program of Santa Barbara County Santa Maria	(805) 563-6025 (805) 928-4808
Santa Clara	LTC Ombudsman Program	(408) 944-0567

County	*Center*	*Phone*
Santa Cruz	Ombudsman/Advocacy, Inc.	(831) 429-1913
Shasta	Northern CA Ombudsman Program	(530) 223-6191
Sierra	Ombudsman Services of Northern California	(916) 376-8910 (530) 274-2825
Siskiyou	Northern CA Ombudsman Program	(530) 223-6191
Solano	LTC Ombudsman Services	(707) 644-4194 Only (707) area: (800) 644-4194
Sonoma	Ombudsman Program	(707) 526-4108
Stanislaus	Ombudsman Program	(209) 529-3784
Sutter	Ombudsman Services of Northern California	(916) 376-8910 (530) 755-2018
Tehama	Ombudsman Program	(530) 898-5923 (800) 822-0109
Trinity	Northern CA Ombudsman Program	(916) 223-6191
Tulare	LTC Ombudsman Program	(559) 583-0333
Tuolumne	Mother Lode Ombudsman Program	(209) 532-7632
Ventura	LTC Ombudsman Services of Ventura County, Inc.	(805) 656-1986
Yolo	Ombudsman Services of Northern California	(916) 376-8910 (530) 668-5775
Yuba	Ombudsman Services of Northern California	(916) 376-8910 (530) 755-2018

Appendix 3-C

County Child Welfare Services Mailing Addresses and Emergency Response (Reporting) Telephone Numbers

ALAMEDA
Director, Alameda County CWS Agency
P.O. Box 12941
Oakland, CA 94607
(510) 259-1800

ALPINE
Director, Alpine County CWS Agency
75-A Diamond Valley Road
Markleeville, CA 96120
(888) 755-8099 24 hours
(530) 694-2235

AMADOR
Director, Amador County CWS Agency
1003 Broadway
Jackson, CA 95642
(209) 223-6550 days
(209) 223-1075 after hours

BUTTE
Director, Butte County CWS Agency
P.O. Box 1649
Oroville, CA 95965
(530) 538-7617 Oroville; (800) 400-0902 others

CALAVERAS
Director, Calaveras County CWS Agency
891 Mountain Ranch Road
San Andreas, CA 95249-9709
(209) 754-6452 days; (209) 754-6500 after hours

COLUSA
Director, Colusa County CWS Agency
P.O. Box 370
Colusa, CA 95932
(530) 458-0280

CONTRA COSTA
Director, Contra Costa County CWS Agency
40 Douglas Drive
Martinez, CA 94553-4068
(925) 646-1680 central; (510) 374-3324 west;
(510) 925-427-8811 east

DEL NORTE
Director, Del Norte County CWS Agency
Crescent City, CA 95531
(707) 464-3191

EL DORADO
Director, El Dorado County CWS Agency
3057 Briw Road
Placerville, CA 95667
(530) 544-7236 S. Tahoe
(530) 642-7100 Placerville

FRESNO
Director, Fresno County CWS Agency
2600 Ventura Street
Fresno, CA 93750
(559) 255-8320

GLENN
Director, Glenn County CWS Agency
P.O. Box 611
Willows, CA 95988
(530) 934-6520

HUMBOLDT
Director, Humboldt County CWS Agency
929 Koster Street
Eureka, CA 95501
(707) 445-6180

IMPERIAL
Director, Imperial County CWS Agency
2995 South 4th Street, Suite 105
El Centro, CA 92243
(760) 337-7750

INYO
Director, Inyo County CWS Agency
Courthouse Annex, Drawer A
Independence, CA 93526-0601
(760) 872-1727

KERN
Director, Kern County CWS Agency
PO Box 511
Bakersfield, CA 93302
(661) 631-6011 days

KINGS
Director, Kings County CWS Agency
1200 South Drive
Hanford, CA 93230
(559) 582-8776

LAKE
Director, Lake County CWS Agency
P.O. Box 9000
Lower Lake, California 95457
(707) 262-0235

LASSEN
Director, Lassen County CWS Agency
Post Office Box 1359
Susanville, CA 96130
(530) 251-8277 days
(530) 257-6121 Sheriff (after hours)

LOS ANGELES
Director, Los Angeles County CWS Agency 880
Northcrest Drive
425 Shatto Place
Los Angeles, CA 90020
(800) 540-4000 in-state; (213) 639-4500 out-of-state

MADERA
Director, Madera County CWS Agency
700 East Yosemite Avenue
Madera, CA 93638
(559) 675-7829
(800) 801-3999

MARIN
Director, Marin County CWS Agency
20 North San Pedro Rd, Suite 2028
San Rafael, CA 94903
(415) 499-7153
(415) 479-1601 TDD

MARIPOSA
Director, Mariposa County CWS Agency
5186 Highway 49 North
Mariposa, CA 95338
(209) 966-3030

MENDOCINO
Director, Mendocino County CWS Agency
P.O. Box 1060
Ukiah, CA 95482
(707) 463-5600

MERCED
Director, Merced County CWS Agency
Post Office Box 112
Merced, CA 95341
(209) 385-3104 days
(209) 385-9915 (after hours)

MODOC
Director, Modoc County CWS Agency
120 North Main Street
Alturas, CA 96101
(530) 233-6501 days; (530) 233-4416 after hours

MONO
Director, Mono County CWS Agency
Post Office Box 576
Bridgeport, CA 93517
(760) 932-7755 or (800) 340-5411 (statewide)

MONTEREY
Director, Monterey County CWS Agency
1000 South Main Street, Suite 209-A
Salinas, CA 93901
(831) 755-4661

NAPA
Director, Napa County CWS Agency
2261 Elm Street
Napa, CA 94559
(707) 253-4261

NEVADA
Director, Nevada County CWS Agency
P.O. Box 1210
Nevada City, CA 95959
(530) 265-9380

ORANGE
Director, Orange County CWS Agency
888 North Main Street
Santa Ana, CA 92701
(714) 940-1000
(800) 207-4464

PLACER
Director, Placer County CWS Agency
11730 Enterprise Drive
Auburn, CA 95603
(530) 886-5401
(916) 787-8860 Roseville/Rocklin/Granite Bay

PLUMAS
Director, Plumas County CWS Agency
270 County Hospital Road, Suite 207
Quincy, CA 95971
(530) 283-6350

RIVERSIDE
Director, Riverside County CWS Agency
4060 County Circle Drive
Riverside, CA 92503
(800) 442-4918

SACRAMENTO
Director, Sacramento County CWS Agency
7001 East Parkway, Suite A
Sacramento, CA 95823
(916) 875-5437

SAN BENITO
Director, San Benito County CWS Agency
1111 San Felipe Road, Suite 206
Hollister, CA 95023
(831) 636-4190 days
(831) 636-4330 after hours

SAN BERNARDINO
Director, San Bernardino County CWS Agency
385 North Arrowhead Avenue, 5th Floor
San Bernardino, CA 92415
(800) 827-8724
(909) 422-3266 after hours

SAN DIEGO
Director, San Diego County CWS Agency
1700 Pacific Highway, MS P501
San Diego, CA 92101
(858) 560-2191

SAN FRANCISCO
Director, San Francisco County CWS Agency
P. O. Box 7988
San Francisco, CA 94120
(415) 558-2650
(800) 856-5553

SAN JOAQUIN
Director, San Joaquin County CWS Agency
P.O. Box 201056
Stockton, CA 95201-3006
(209) 468-1333
(209) 468-1330

SAN LUIS OBISPO
Director, San Luis Obispo County CWS Agency
P. O. Box 8119
San Luis Obispo, CA 93403-8119
(805) 781-5437
(800) 834-5437

SAN MATEO
Director, San Mateo County CWS Agency
400 Harbor Boulevard
Belmont, CA 94002
(650) 595-7922
(800) 632-4615
(650) 595-7518 fax

SANTA BARBARA
Director, Santa Barbara County CWS Agency
234 Camino Del Remedio
Santa Barbara, CA 93110
(800) 367-0166 days
(805) 737-7078 Lompoc
(805) 683-2724 after hours

SANTA CLARA
Director, Santa Clara County CWS Agency
1725 Technology Drive
San Jose, CA 95110
(408) 299-2071 North
(408) 683-0601 South

SANTA CRUZ
Director, Santa Cruz County CWS Agency
1000 Emeline Avenue
Santa Cruz, CA 95060
(831) 454-4222
(831) 763-8850 Watsonville

SHASTA
Director, Shasta County CWS Agency
P.O. Box 496005
Redding, CA 96049-6005
(530) 225-5144

SIERRA
Director, Sierra County CWS Agency
P. O. Box 1019
Loyalton, CA 90118
(530) 289-3720 24 hours
(530) 993-6720 business hours only

SISKIYOU
Director, Siskiyou County CWS Agency
818 South Main Street
Yreka, CA 96097
(530) 841-4200 business hours only
(530) 842-7009 24 hours

SOLANO
Director, Solano County CWS Agency
P.O. Box 4090, MS 3-220
Fairfield, CA 94533
800-544-8696

SONOMA
Director, Sonoma County CWS Agency
P. O. Box 1539
Santa Rosa, CA 95402-1539
(707) 565-4304

STANISLAUS
Director, Stanislaus County CWS Agency
P. O. Box 42
Modesto, CA 95353-0042
(800) 558-3665

SUTTER
Director, Sutter County CWS Agency
P. O. Box 1535
Yuba City, CA 95992-1535
(530) 822-7155

TEHAMA
Director, Tehama County CWS Agency
P.O. Box 1515
Red Bluff, CA 96080
(800) 323-7711
(530) 527-9416

TRINITY
Director, Trinity County CWS Agency
P. O. Box 1470
Weaverville, CA 96093-1470
(530) 623-1314

TULARE
Director, Tulare County CWS Agency
5957 South Mooney Boulevard
Visalia, CA 93277
(800) 331-1585; (559) 730-2677 county only

TUOLUMNE
Director, Tuolumne County CWS Agency
20075 Cedar Road North
Sonora, CA 95370
(209) 533-5717 days; (209) 533-4357 after hours

VENTURA
Director, Ventura County CWS Agency
505 Poli Street
Ventura, CA 93001
(805) 654-3200

YOLO
Director, Yolo County CWS Agency
25 North Cottenwood Street
Woodland, CA 95695
(530) 669-2345; (530) 669-2346; (530) 666-8920
(888) 400-0022 after hours

YUBA
Director, Yuba County CWS Agency
P. O. Box 2320
Marysville, CA 95901
(530) 749-6288

Appendix 3-D

Adult Protective Services County Contact List

Alameda County
Department of Adult and Aging Services
8000 Edgewater Drive
Oakland, CA 94621

WEBSITE:
www.co.alameda.ca.us/assistance/adult/APS.shtml

HOTLINE*: (510) 567-6894

Fax: (510) 569-5384

Alpine County
Department of Health and Human Services
75-A Diamond Valley Road
Markleeville, CA 96120

WEBSITE:
www.co.alpine.ca.us/dept/soc_srv/socserv.html

HOTLINE*: (888) 755-8099

Fax: (530) 694-2252

Amador County
Department of Social Services
1003 Broadway
Jackson, CA 95642

WEBSITE:
www.co.amador.ca.us/pub/depts/hhs/socialsvcs/aps/default.htm

HOTLINE*: (209) 223-1075

Fax: (209) 223-6579

Butte County
Department of Social Services
Post Office Box 1649
Oroville, CA 95965

WEBSITE:
www.buttecounty.net/dessSenior_Adult.html

HOTLINE*: (800) 664-9774

Fax: (530) 579-3614

Calaveras County
CalWORKs & Human Services Agency
891 Mountain Ranch Road
San Andreas, CA 95249

WEBSITE:
www.co.calaveras.ca.us/departments/welfare.html

Sheriff's Office: (209) 754-6500

Fax: (209) 754-6579

Colusa County
Department of Health and Human Services
251 East Webster Street
Colusa, CA 95932

WEBSITE:
www.colusacountyclerk.com

HOTLINE*: (530) 458-0280

Fax: (530) 458-0492

Contra Costa County
Department of Aging and Adult Services
2530 Arnold Drive, Suite 300
Martinez, CA 94553-4359

WEBSITE:
www.ehsd.org/adult/adult001.html

HOTLINE*: (877) 839-4347

Fax: (925) 335-8738

Del Norte County Supervisor
Social Services Department
880 Northcrest Drive
Crescent City, CA 95531

WEBSITE:
www.co.del-norte.ca.us

HOTLINE*: (707) 464-3191

Fax: (707) 465-1783

El Dorado County
Department of Social Services
3057-A Briw Road
Placerville, CA 95667-5321

WEBSITE:
http://co.el-dorado.ca.us/socialservices/adultprotect.html

HOTLINE*: (800) 925-1812

Fax: (530) 543-6774

Fresno County
Human Services System
Department of Adult Services
Post Office Box 1912
Fresno, CA 93750-0001

WEBSITE:
http://www.fresno.ca.gov/5600/AS/AdultProtectiveServices.htm

HOTLINE*: (559) 255-3383

Fax: (559) 453-4736

Glenn County
Human Resources Agency
Mailing Address:
P.O. Box 611
Physical Address:
420 East Laurel Street
Willows, CA 95988-0611

WEBSITE:
www.countyofglenn.net

HOTLINE*: (530) 934-6520

Fax: (530) 934-6521

Humboldt County
Department of Social Services
808 E Street
Eureka, CA 95501

WEBSITE:
www.co.humboldt.ca.us/welfare/adult-1.htm

HOTLINE*: (707) 445-6180

Fax: (707) 476-2138

Imperial County
Department of Social Services
315 South Waterman
El Centro, CA 92243

WEBSITE:
http://co.imperial.ca.us/socialservices/

HOTLINE*: (760) 337-7878

Fax: (760) 336-3971

Inyo County
Department of Health and Human Services
162 Grove Street
Bishop, CA 93514

WEBSITE:
www.countyofinyo.org

HOTLINE*: (800) 841-5011

Fax: (760) 873-3277

Kern County
Aging and Adult Services Department
Protective Services Division
5357 Truxton Avenue
Bakersfield, CA 93309

WEBSITE:
http://www.co.kern.ca.us/aas/protectiveservices.asp

HOTLINES*: (661) 868-1006; (800) 277-7866

Kings County
Human Services Agency
Government Center
1200 South Drive
Hanford, CA 93230

WEBSITE:
www.countyofkings.com/HSA/index.htm

HOTLINES*: (559) 582-8776; (877) 897-5842

Fax: (559) 585-0346

Lake County
Social Services Department
Post Office Box 9000
Lower Lake, CA 95457

WEBSITE:
http://dss.co.lake.ca.us/adultprotectiveservices.html

LOCAL HOTLINE*: (800) 386-4090

Pager: (800) 399-9339
Fax: (707) 262-0299

Lassen County
Welfare Administration/ LassenWorks
Post Office Box 1359
Susanville, CA 96130

WEBSITE:
www.co.lassen.ca.us/welfare_mission.htm

HOTLINE*: (530) 251-8158

Sheriff's Office: (530) 251-8222 (Night Calls)
Fax: (530) 251-8370

Los Angeles County
Community and Senior Services
3333 Wilshire Blvd., Suite 400
Los Angeles, CA 90010

WEBSITE:
http://dcss.co.la.ca.us/APS/APS.htm

HOTLINE*: (877) 477-3646

Direct/Collect: (626) 579-6905
Intake Fax: (213) 738-6485

Madera County
Department of Social Services
Post Office Box 569
Madera, CA 93639

WEBSITE:
www.madera-county.com

HOTLINE*: (559) 675-7839

Fax: (559) 675-7690

Marin County
Department of Health and Human Services
10 North San Pedro Rd., Suite 1007
San Rafael, CA 94903

WEBSITE:
www.co.marin.ca.us/depts/HH/main/ss/atisfaq.cfm#adult

HOTLINE*: (415) 507-2774
Fax: (415) 499-6465

Mariposa County
Department of Human Services
Post Office Box 7
Mariposa, CA 95338

WEBSITE:
www.mariposacounty.org

HOTLINE*: (800) 266-3609
Fax: (209) 742- 5854

Mendocino County
Department of Social Services
Post Office Box 839
Ukiah, CA 95482

WEBSITE:
www.co.mendocino.ca.us

HOTLINE*: (707) 962-1102
Fax: (707) 962-1110

Merced County
Department of Human Services
Post Office Box 112
Merced, CA 95341

WEBSITE:
www.co.merced.ca.us

HOTLINE*: (209) 385-3105
Fax: (209) 725-3836

Modoc County
Department of Social Services
120 North Main Street
Alturas, CA 96101

WEBSITE: N/A

(530) 233-6501
Sheriff's Office: (530) 233-4416
(Night calls)
Fax: (530) 233-6536

Mono County
Department of Social Services
Post Office Box 576
Bridgeport, CA 93517

WEBSITE:
www.monocounty.ca.gov

HOTLINE*: (800) 340-5411
Fax: (760) 932-5287

Monterey County
Department of Social Services
713 Laguardia Street, Suite A
Salinas, CA 93901

WEBSITE:
www.co.monterey.ca.us

HOTLINE*: (800) 960-0010
Fax: (831) 899-8022

Napa County
Health and Human Services Agency
900 Coombs Street, #257
Napa, CA 94559-2936

WEBSITE:
http://www.co.napa.ca.us/departments/AdultProtective/default.asp

HOTLINE*: (888) 619-6913
Fax: (707) 253-6117

Nevada County
Department of Human Services
PO Box 1210
950 Maidu Avenue
Nevada City, CA 95959

WEBSITE:
http://afs.co.nevada.ca.us/ourservices.htm

HOTLINE*: (888) 339-7248
Fax: (530) 265-7166

Orange County
Social Services Agency
Post Office Box 22006
Santa Ana, CA 92702-2006

WEBSITE:
www.oc.ca.gov./ssa/adltserv/asaps.htm

HOTLINE*: (800) 451-5155
Fax: (714) 825-3155

Placer County
Health and Human Services Department
11512-B Avenue
Auburn, CA 95603

WEBSITE:
www.placer.ca.gov/hhs/access.htm

HOTLINE*: (888) 886-5401

Fax: (530) 886-2992

Plumas County
Department of Social Services
270 County Hospital Road, Suite 207
Quincy, CA 95971

WEBSITE:
www.countyofplumas.com/socialservices/socialservices_home_page.htm

HOTLINE*: (530) 283-6471

Sheriff's Office: (530) 283-6300 (Night Calls)
Fax: (530) 283-6368

Riverside County
Department of Public Social Services
4060 County Circle Drive
Riverside, Ca 92503

WEBSITE:
http://dpss.co.riverside.ca.us/aps1.htm

HOTLINE*: (800) 491-7123

Fax: (909) 358-3364

Sacramento County
Department of Health and Human Services
4875 Broadway
Sacramento, CA 95820

WEBSITE:
www.sacdhhs.com/senior.html

HOTLINE*: (916) 874-9377

Fax: (916) 874-9682

San Benito County
Health and Human Services Agency
1111 San Felipe Road, Suite 206
Hollister, CA 95023

WEBSITE:
www.san-benito.ca.us

HOTLINE*: (831) 636-4190

Fax: (831) 637-2910

San Bernardino County
Human Services System
686 East Mill Street
San Bernardino, CA 92415-0640

WEBSITE:
http://hss.sbcounty.gov/daas/Programs/a.htm

HOTLINE*: (877) 565-2020

Fax: (909) 335-0650

San Diego County
Aging and Independence Services
9335 Hazard Way, Suite 100
San Diego, CA 92123

WEBSITE:
www.ais-sd.net/

HOTLINES*: (858) 495-5660; (800) 339-4661
Local*): (800) 227-0997

Fax: (858) 495-5247

San Francisco City and County
Department of Human Services
Post Office Box 7988
San Francisco, CA 94120-7988

WEBSITE:
www.ci.sf.ca.us/dhs/aps.htm

HOTLINES*: (800) 814-0009
(415) 557-5230

Fax: (415) 557-5377

San Joaquin County
Human Services Agency-Aging and Community Services
Post Office Box 201056
Stockton, CA 95201

WEBSITE:
www.co.san-joaquin.ca.us/aging/direct.htm

HOTLINE*: (888) 800-4800

Fax: (209) 468-2207

San Luis Obispo County
Department of Social Services
Post Office Box 8119
San Luis Obispo, CA 93403-8119

WEBSITE:
www.slodss.org/adult_services/index.htm

(805) 781-1790
After Hours: (800) 838-1381
Fax: (805) 788-2512

San Mateo County
Department of Health Services
Aging and Adult Services
225 37th Avenue
San Mateo, CA 94403

WEBSITE:
www.smhealth.org/aging.html

HOTLINE*: (800) 675-8437

Fax: (650) 573-2193

Santa Barbara County
Department of Social Services
234 Camino Del Remedio
Santa Barbara, CA 93110-1369

WEBSITE:
www.countyofsb.org

HOTLINE*: (805) 692-4011

Fax: (805) 681-4579
Fax: (805) 346-7246

Santa Clara County
Social Services Agency
591 North King Road
San Jose, CA 95133

WEBSITE:
http://santaclaracounty.org/ssa/daas/apshome.htm

HOTLINE*: (800) 414-2002

Fax: (408) 923-2134

Santa Cruz County
Human Resources Agency
Post Office Box 1320
Santa Cruz, CA 95061

WEBSITE:
www.hra.co.santa-cruz.ca.us/html/aps.html

HOTLINES*: (866) 580-HELP
(866) 580- 4357

Fax: (831) 454-4290

Shasta County
Department of Social Services
Post Office Box 496005
Redding, CA 96049-6005

WEBSITE:
www.co.shasta.ca.us/Departments/SocialServices/Index.htm#Adult

HOTLINE*: (530) 225-5798

Fax: (530) 245-7693

Sierra County
Department of Health and Human Services
Post Office Box 1019
Loyalton, CA 96118

WEBSITE:
www.sierracounty.ws

HOTLINE*: (530) 289-3720

Fax: (530) 993-6767 (Loyalton)
Fax: (530) 289-3716 (Downieville)

Siskiyou County
Human Services Department
490 South Broadway
Yreka, CA 96097

WEBSITE:
www.co.siskiyou.ca.us/humsvc/adult.htm

HOTLINE*: (530) 842-7009

Fax: (530) 841-4238

Solano County
Department of Health and Social Services
Older and Disabled Adult Services
275 Beck Avenue
PO Box 5050
Fairfield, CA 94533

WEBSITE:
www.co.solano.ca.us/hss/

HOTLINE*: (800) 850-0012

Fax: (707) 435-2440

Sonoma County
Human Services Department
Post Office Box 4059
Santa Rosa, CA 95402

WEBSITE:
www.sonoma-county.org/human/division.htm#b_a

HOTLINE*: (800) 667-0404

Fax: (707) 565-5969

Stanislaus County
Community Services Agency
Post Office Box 42
Modesto, CA 95353-0042

WEBSITE:
www.stanworks.com/departments/adultservices/aps.htm

HOTLINE*: (800) 336-4316

Fax: (209) 558-2681

Sutter County
Department of Human Services
Post Office Box 1599
Yuba City, CA 95991

WEBSITE:
www.co.sutter.ca.us/human_services/welfare_social_services/index.htm

HOTLINE*: (530) 822-7227

Fax: (530) 822-7384

Tehama County
Department of Social Services
Post Office Box 1515
Red Bluff, CA 96080

WEBSITE: N/A

HOTLINE*: (800) 323-7711

Fax: (530) 527-5410

Trinity County
Health and Human Services Department
Post Office Box 1470
Weaverville, CA 96093-1470

WEBSITE:
www.trinitycounty.org

HOTLINE*: (530) 623-1314

or (800) 851-5658
Fax: (530) 623-6628

Tulare County
Department of Public Social Services
3330 West Mineral King Road., Suite A
Visalia, CA 93291

WEBSITE:
www.co.tulare.ca.us

HOTLINE*: (800) 321-2462

Fax: (559) 740-4347

Tuolumne County
Department of Social Services
20075 Cedar Road North
Sonora, CA 95370

WEBSITE: N/A

HOTLINE*: (209) 533-4357

Fax: (209) 533-7355; (209) 533-5714

Ventura County
Human Services Agency
505 Poli Street
Ventura, CA 93003

WEBSITE:
www.ventura.org/hsa/htm/adultpro.htm

HOTLINE*: (805) 654-3200

Fax: (805) 652-7502

Yolo County
Department of Employment
and Social Services
500-A Jefferson Boulevard, Suite 100
West Sacramento, CA 95605

WEBSITE:
www.yolocounty.org/org/dess/apsdiv.htm

HOTLINES*: (916) 375-6239
(888) 675-1115

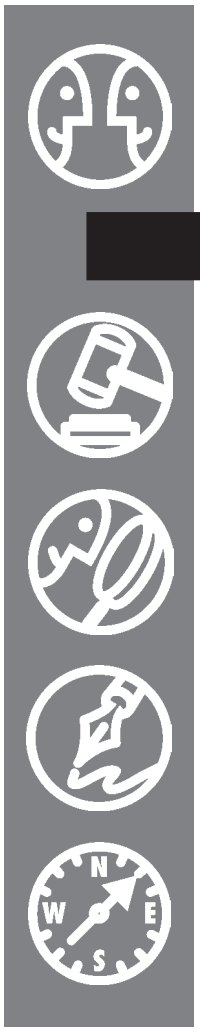
Fax: (916) 375-6203

Yuba County
Health and Human Services Department
6000 Lindhurst Avenue, Suite 700-C
P.O. Box 2320
Marysville, CA 95901

WEBSITE:
www.co.yuba.ca.us/departments.html

HOTLINE*: (530) 749-6471

Fax: (530) 749-6244



Student Resource Guide

4. Medication Management, Part 1

Student Resource Guide: SESSION 4

Medication Management: Part 1

OUTCOMES

When you finish this session you will be able to:

- Demonstrate how to assist individuals in the self-administration of medication.
- Identify resources for information about medications that individuals are taking.
- Identify the Five Rights of assisting an individual with self-administration of medication.
- Identify the difference between "prescription" and "over-the-counter" medications.
- Identify key information on prescription medication labels.
- Document self-administration of medication.

KEY WORDS

Drug: A word often used interchangeably with the word medication.

Generic Name: The name given by the federal government to a drug.

Medication: Substance taken into (or applied to) the body for the purpose of preventio¡n, treatment, relief of symptoms, or cure.

Medication (Drug) Interactions: The result, either desirable or undesirable, of drugs interacting with themselves, other drugs, foods, alcohol, or other substances, such as herbs or other nutrients.

Ophthalmic: Refers to the eyes.

Otic: Refers to the ears.

Over-the-Counter Medications: All non-prescription medications including aspirin, antihistamines, vitamin supplements, and herbal remedies.

Pharmacist: Licensed individual who prepares and dispenses drugs and is knowledgeable about their contents.

Physician/Doctor: An individual licensed to practice medicine. For the purpose of prescribing medications only, the term is interpreted to mean any health care professional authorized by law to prescribe drugs: physician, dentist, optometrist, podiatrist, nurse practitioner, physician's assistant. A nurse practitioner or physician's assistant who writes prescriptions is acting under the supervision of the individual's physician.

Prescription Medications: Medications that must be ordered by a physician or other licensed health care professional with authority to write prescriptions, such as a dentist or nurse practitioner.

Side Effects: Effects produced by medication other than those for which it was prescribed. Sometimes side effects, such as a severe allergic reaction, can be deadly.

Topical: Applied to a certain area of the skin.

Trade Name/Brand Name: The name given by the manufacturer to a medication.

Overview

Of the 2.3 billion prescriptions that are filled annually, approximately half are not taken properly. Failure of Americans to take their medication as instructed costs more than $100 billion a year in increased hospital and nursing home admissions, lost worker productivity, and premature death.

Many of the people you support take at least one or more medications on an ongoing basis. Everyone you support will need to take medication(s) at one time or another.

Some of you have been assisting with medication for a long time. For others this may be a new responsibility. Whatever your level of experience, assisting with medication is a very high-risk activity. The critical skills you will learn in the next two sessions are designed to increase safety and reduce the risk of error, thereby providing maximum protection for the individuals you assist as well as yourself. No one wants to be responsible for causing injury or harm to someone else. The information being shared in this training will help prevent that.

The health of many individuals in licensed community care homes depends on the skills of the DSP in assisting them in taking medications. The DSP's role in assisting individuals to take the right medication, in the right dose, by the right route, at the right time is a very important function.

Medications are substances taken into (or applied to) the body for the purpose of prevention, treatment, relief of symptoms, or cure. Knowing about medications, their use and abuse, and how to assist individuals in using them is vital to the health and well-being of those you serve.

In this section you will learn how to safely assist people with prescribed medications. You will learn how to:

- Get information about medications from the **doctor** and **pharmacist**.
- Read and understand the medication label.
- Follow the **Five Rights** (fully discussed on page 12) for medication management:

  Right individual

  Right medication

  Right dose

  Right time

  Right route
- Document each dose of medication taken, as well as any medication errors.
- Observe the individual for both intended effects and unintended side effects.
- Report and document any side effects.

Requirements for Assisting with Medications

In California, community care licensing regulations are very specific regarding requirements for assisting with medications. Some of the regulations are different based upon the age of individuals living in the home and the home's licensing category; for example, Adult Residential Facility or Small Family Home. Specific information on these regulatory requirements is included in the Community Care Licensing Division's *Self Assessment Guide, Medications Booklet* published in September 2002, and found in Appendix 4-E.

The DSP may only assist individuals with self-administration of medications that have been ordered and prescribed by a doctor, dentist, or nurse practitioner. This includes both prescription and over-the-counter medications. The doctor's signed, dated order or prescription provides instructions for preparation and administration of the medication.

Prescription medications are those that are always ordered by a doctor or other person with authority to write a prescription. **Over-the-counter (OTC)** medications are those that typically can be bought without a doctor's order and include vitamin supplements, herbal remedies, and commonly used medications such as Tylenol and Benadryl.

Effects of Medication

Intended Effects

All medications are powerful substances and should be treated with respect and care. Medications affect each individual differently. They can do a lot of good for individuals; however, they may also cause harm. Usually a medication is taken for a primary or intended effect or action, such as controlling seizures, lowering blood pressure, or relieving pain.

Side Effects

Many drugs have other known actions besides the primary or intended one. These actions are called secondary actions or **side effects**. Many of these effects are predictable; however, some are not. Side effects may be desirable or undesirable, harmless or dangerous. Sometimes they can even be deadly. Both prescription and OTC drugs have side effects.

An example of a side effect is when the medication makes the individual feel nauseated, confused, dizzy, or anxious, or when it causes a rash or a change in a bodily function such as a change in appetite, sleep pattern, or elimination.

It is not uncommon for two or more medications to interact with one another causing unwanted side effects. An example of this would be when iron or Penicillin is given with an antacid. The antacid prevents the iron or Penicillin from being absorbed in the stomach.

Common Categories of Medication

Drugs are classified into categories or classes with other medications that affect the body in similar ways. Thousands of medications are on the market. Many drugs, because of their multiple uses, can be found in more than one category. Some of the common categories of medications used by individuals with developmental disabilities include anticonvulsants, antibiotics, pain medications, topical ointments or creams, and psychotropic medications that include antidepressants and antipsychotics.

Reading and Understanding Medication Labels

Remember, the DSP can only assist individuals with self-administration of medications that have been ordered or prescribed by a doctor, dentist, or nurse practitioner. This includes both prescription and OTC medications. The pharmacist prepares the medication using the doctor's written order and places a label on the medication container that provides instructions for taking the medication.

Medications have both a **generic name** and a **trade name**. The generic name is the name given by the federal government to a drug. The trade or brand name is the name given by the manufacturer to a medication. For example, acetaminophen is the generic name for Tylenol. Tylenol is the trade name. The prescribing doctor may order the medication by either name. The pharmacy label may have either name as well.

Each prescribed medication must be kept in its original container with the pharmacy label attached. Careful reading of the label is critical to ensuring medication safety. The information on the pharmacy medication label includes:

- Pharmacy/pharmacist name and address.
- Prescription number or other means of identifying the prescriber (used in requesting refills).
- Individual's name.
- Prescriber's name (doctor).
- Name of medication.
- Strength (dose).
- Directions for how to use the medication.
- Manufacturer.
- Quantity (for example, number of pills, or other measurement of the amount of the prescription).
- Date the prescription was filled.
- Expiration or discard date.
- Number of refills remaining.
- Condition for which prescribed (most pharmacies include this information if it is on the doctor's order.)

Pharmacy Abbreviations and Symbols

The following abbreviations and symbols are commonly used on medication labels. In order to read and understand medication labels, the DSP must be familiar with these abbreviations and symbols.

- Rx = Prescription
- OTC = Over-the-Counter
- p.r.n. = when necessary, or as needed
- Qty = quantity
- q (Q) = every
- qd = daily
- b.i.d. (BID) = twice a day
- t.i.d. (TID) = three times a day
- q.i.d. (QID) = four times a day
- h. = hour
- h.s. (HS) = hour of sleep (bedtime)
- tsp. = teaspoon (or 5 ml)
- Tbsp. = tablespoon (3 tsps or 15 ml)
- oz = ounce
- gr = grains
- mg = milligrams
- GM, gm = grams (1,000 mg)
- Cap = capsule
- Tab = tablet
- A.M. = morning
- P.M. = afternoon/evening
- D/C or d/c = discontinue

ACTIVITY

Medication Label Abbreviations

Directions: Draw a line from each abbreviation to its meaning.

Abbreviation	Meaning
q.i.d (QID)	afternoon/evening
Tab	morning
P.M.	teaspoon
Tbsp.	twice a day
b.i.d (BID)	capsule
A.M.	ounce
t.i.d (TID)	four times a day
Cap	tablespoon
oz.	tablet
tsp.	three times a day

Reading and Understanding Medication Labels (continued)

The dose is a term used to describe how much medication or how many units are to be taken at any time. A dose can be described as a single dose or a daily dose. For example, an oral medication (capsules or tablets) may be prescribed as:

AMOXICILLIN 500 mg capsules
Take 1 capsule 3 times daily

In this example the individual is taking a 500 mg single dose and a 1500 mg daily dose.

TEGRETOL 200 mg tabs
2 tabs at 7a.m. • 2 tabs at 2p.m. and 1 tab at 9p.m.

In this example the individual is taking a 400 mg single dose and a 1000 mg daily dose.

A liquid medication may be prescribed as:

AMOXICILLIN 250 mg/5cc.
Give 5 cc (5cc= 1 teaspoon) 4 times a day or Q.I.D.

In this example the individual is taking a 5 cc single dose and a 20 cc daily dose.

Reading and Understanding Medication Labels (continued)

Oral medications (capsules or tablets) are usually prescribed in mg (milligrams) or gm (grams).

Liquid medications are usually prescribed in ml (milliliters), cc (centimeters), or oz (ounces). Liquid medications may also be prescribed in tsp (teaspoon), or tbsp (tablespoon).

A typical medication label looks like the one shown on the right.

Do not "scratch out," write over, or change a drug label in any way. Any change to a prescription requires a new doctor's order that must be refilled by the pharmacist.

ABC Pharmacy
Dr. Anderson

RX 10483 6/04/05

JACOB SMITH
TAKE 1 TABLET ORALLY EVERY 8 HOURS FOR 10 DAYS FOR BRONCHITIS
8 a.m., 4 p.m., 12 a.m.

AMOXICILLIN 250 MG
#30 TABLETS

EXPIRES: 7/01/06 NO REFILLS

MFG: MANY MEDICATIONS, INC
FILLED BY: BRS

Sample Medication Label Worksheet

Directions: Use the sample medication label above to answer the following questions.

What is the RX number? _____

Who prescribed the medication? _____

What is the name of the medication? _____

What is the individual dose? _____

When should it be taken? _____

For how long? _____

What date did the pharmacy fill the medication? _____

Who is the medication prescribed for? _____

How many refills? _____

What is the expiration or discard date? _____

Is there any information missing? _____

Who is the manufacturer? _____

Reading and Understanding Medication Labels (continued)

Label Warnings

Medication containers may also have separate warning labels affixed by the pharmacist that provide additional information on the use of the medication; for example, "Medication Should Be Taken with Plenty of Water." Some additional examples are listed below:

For External Use Only

Do Not Take With Dairy Products, Antacids or Iron Preparations Within One Hour of This Medication

Finish All This Medication Unless Otherwise Directed by Prescriber

Take Medication on an Empty Stomach 1 hour Before or 2 Hours After a Meal Unless Otherwise Directed by Your Doctor

May Cause Drowsiness or Dizziness

May Cause Discoloration of the Urine or Feces

It May Be Advisable to Drink a Full Glass of Orange Juice or Eat a Banana Daily

Learning About Medications

Medication safety includes learning about the medications that you are assisting another to take. You need to know the answers to all of the following questions:

- What is the medication, and why is it prescribed?
- What is the proper dosage, frequency, and method for taking the medication (for example by mouth, topical)?
- How many refills are needed?
- What are the start and end dates for the medication? Should it be taken for 7 days, 10 days, a month?
- Are there possible side effects, and to whom should these side effects be reported?
- What should be done if a dose is missed?
- Are there any special storage requirements?
- Are there any special instructions for use of this medication? For example, should certain foods, beverages, other medicines, or activities be avoided?
- What improvements should be expected, and when will they start showing?

To obtain this information, talk to the prescribing doctor and the pharmacist who fills the doctor's order. Also ask the pharmacist for a copy of the medication information sheet and have him or her go over it with you. Other sources of information include medication reference books from your local library or bookstore. Websites such as *safemedication.com* or *rxlist.com* also provide medication information.

When talking to the doctor or pharmacist, use the Medication Safety Questionnaire on the opposite page to make sure you get all your questions answered.

ACTIVITY

Medication Safety Questionnaire

Directions: Using the sample medication label, and the medication information sheet in Appendix 4-F, fill in the answers on the Medication Safety Questionnaire. There is a blank copy of the Medication Safety Questionnaire in Appendix 4-G for you to use with the individuals you assist.

ABC Pharmacy
Dr. Anderson
RX 10483 6/04/05
JACOB SMITH
TAKE 1 TABLET ORALLY EVERY 8 HOURS FOR 10 DAYS FOR BRONCHITIS
8 a.m., 4 p.m., 12 a.m.

AMOXICILLIN 250 MG
#30 CAPSULES

EXPIRES: 7/01/06 NO REFILLS
MFG: MANY MEDICATIONS, INC
FILLED BY: BRS

ACTIVITY

Medication Safety Questionnaire

Name			
Brand: _____ Generic: _____	Dose (e.g., mg) and form (e.g., tabs)	When to take each dose?	For how long?

1. What is the medication supposed to do?

2. How long before I will know it is working or not working?

3. What about serum (blood) levels? Other laboratory work? How often? Where? Standing order?

4. If the individual misses a dose, what should I do?

. . . . . .

INTERACTIONS?

5. Should this medication be taken with food? ☐ Yes ☐ No

   At least one hour before or two hours after a meal? ☐ Yes ☐ No

6. Are there any foods, supplements (such as, herbs, vitamins, minerals), drinks (alcoholic, for example), or activities that should be avoided while taking this medication?

   ☐ Yes (Which ones?) _____

   ☐ No

7. Are there any other prescription or over-the-counter medications that should be avoided?

   ☐ Yes (Which ones?) _____

   ☐ No

. . . . . .

SIDE EFFECTS? IF SO, RESPONSE?

8. What are common side effects?

9. If there are any side effects, what should I do?

10. If the drug is being prescribed for a long period of time, are there any long-term effects?

Documentation

Medication Log

Medication safety also includes recording each dose of medication taken (or missed for any reason). The DSP can use the sample Medication Log provided (Appendix 4-D) or ask the pharmacist to provide a form for documentation of medication. Most pharmacies will print a Medication Log for home use.

The use of a Medication Log for each individual (also know as a Medication Administration Record) increases medication safety and reduces the risk of errors. The log provides a way for the DSP to document each dose of medication taken, any medication errors, and other pertinent information related to assisting with self-administration of a medication.

The Medication Log includes key information about the individual, including any known drug allergies, and information about the individual's medications, including the name of the medication, dose, and the times and way the medication is to be taken.

To avoid errors, it is advised that pre-made medication labels from the pharmacy be placed on the Medication Log. When possible, appropriate pre-made warning labels should also be placed on the Medication Log (such as "take with food"). **Whenever a prescription is changed, the Medication Log must be updated.**

To document that a medication has been taken, the DSP should write down the date and time in the place provided, and initial for each dose of medication. **This must be done at the time the medication is taken by the individual, not before and not hours later.**

Medication Log

Molina Family Home (Facility Name) | 123 Main Street, Any City, CA 90000 (Address) | (123) 456-7890 (Phone Number)

Name: Jacob Smith Insurance: ☑ Medi-Cal ○ Medicare ○ Insurance No. 000111

Month & Year (MM/YY) June 03 & Date

Drug/Strength/Form/Dose	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ABC Pharmacy 1017 25th St., Sacramento, CA Phone: 000-000-0000 Fax: 000-000-0000 Rx: 10287 Dr. Diaz Patient: Jacob Smith 05/15/01 TAKE ONE TABLET ORALLY AM FOR SEIZURES (8AM) Discard by: 06/01/02 Filled by BRS QTY: 30 Refills: 2 TIGGYETOL 400mg TABLET	8 a.m.	SL	SL	SL	SL	SL	SL	SL	SL	SL																						

Primary Care Physician: Dr. Diaz Pharmacy: ABC Pharmacy

Staff Signatures & Initials: SL for Susan Lyons ____ for ____ ____ for ____

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies:

Five Rights of Assisting with Self-Administration of Medication

Following the **Five Rights** are basic to medication safety. The DSP needs to be sure he or she has the:

- **Right** individual
- **Right** medication
- **Right** dose
- **Right** time
- **Right** route

Following the Five Rights each time is the best way for the DSP to prevent medication errors.

Remember, prevention is the #1 priority!

When assisting an individual, you must read and compare the information on the medication label to the information on the Medication Log three times before the individual takes the medication. By doing so, you are helping to ensure that you are assisting the right individual with the right medication and dose at the right time and in the right route (way). **Never assist an individual with medication from a container that has no label!**

If, at any time, you discover that any of the information does not match, **stop**. You may have the **wrong** individual, be preparing the **wrong** medication in the **wrong** dose at the **wrong** time, or the individual may be about to take the medication in the **wrong** way. Think through each of these possibilities and decide what to do. If you are unsure, you may need to get help. Ask another DSP, the administrator, or in some situations, you may need to call the doctor or pharmacist.

Check the Five Rights three times by reading the medication label information and comparing it to the Medication Log as follows:

☑ **First Check**
When you remove the medication from the storage area

☑ **Second Check**
When you remove the medication from the original labeled container

☑ **Third Check**
Just before you assist the individual to take the medication

In some cases, an adult may independently take their own medication. If an adult is to independently self-administer medication, a physician must provide a written statement that the individual is able to administer and store his or her own medications. In all cases, the medications must be properly stored in a locked cabinet. The DSP should monitor the individual and document and report any changes in the individual's ability to independently take medications to the doctor.

The Five Rights

1. Right Individual

First, read the name of the individual on the pharmacy label for whom the medication is prescribed. When assisting an individual with any medication, it is essential that you know the individual. If uncertain of an individual's name or identity, consult another staff member who knows the individual.

2. Right Medication

After you have verified that you have the right individual, read the name of the medication on the label. To make sure that you have the right medication for the right individual, read the label three times and compare it to the information on the individual's Medication Log.

3. Right Dose

Read the medication label for the correct dosage. Be alert to any changes in the dosage.

- Question the use of multiple tablets providing a single dose of medication.
- Question any change in the color, size, or form of medication.
- Be suspicious of sudden large increases in medication dosages.

4. Right Time

Read the medication label for directions as to when and how often the medication should be taken. Medication must be taken at a specific time(s) of the day. Stay with the individual until you are certain that he or she has taken the medication.

You need to know:

- How long has it been since the individual took the last dose?
- Are foods or liquids to be taken with the medication?
- Are there certain foods or liquids to avoid when taking the medication?
- Is there a certain period of time to take the medication in relation to foods or liquids?
- Is it the right time of day, such as morning or evening?
- What time should a medication be taken when it is ordered for once a day? In the morning? At 12:00 noon? At dinnertime? Usually when a medication is ordered only once a day, it is given in the morning; however, it is best to check with the doctor or pharmacist.

5. Right Route

Read the medication label for the appropriate route or way to take the medication. The route for tablets, capsules, and liquids is "oral." This means that the medication enters the body through the mouth. Other routes include nasal sprays, **topical** (which includes dermal patches or ointments to be applied to the skin), eye drops (**ophthalmic**), and ear (**otic**) drops.

Note: Other more intrusive routes, such as intravenous administrations, intramuscular, or subcutaneous injections; rectal and vaginal suppositories; or enemas are only to be administered by a licensed health care professional.

Steps for Assisting with Medication

The following is a the step-by-step process for assisting an individual with self administration of medications.

1. Help the individual whom you are assisting to wash his or her hands.
2. Wash your hands.

   Handwashing reduces the risk of contamination.
3. Get the Medication Log for the individual you are assisting.

   Double check that you have the Medication Log for the right individual. It's important for you to work with only **one** individual at a time and to complete the task with that individual before assisting another.
4. Gather supplies:
   - Take the medications out of the locked storage container or area. It is a good idea to keep all medications for one individual in one storage unit labeled with the individual's name.
   - Get paper cups for tablets and capsules and a plastic calibrated measuring cup or medication spoon for liquid.
   - Get a glass of water.
   - Gather tissues.
   - Get a pen.
5. As you take each medication container from the individual's storage unit, read the medication label and compare to the Medication Log for the Five Rights:
   - Right individual
   - Right medication
   - Right dose
   - Right time

     Again, check the time on your watch or clock.
   - Right route
7. For tablets or capsules, pour the correct dose into the lid of the container and then into a small paper cup.
   - Pour the correct dose into the bottle cap and **then** into a small paper cup or other container used for holding tablets or capsules before the individual takes them. Pouring a tablet or capsule into the bottle cap first reduces the risk of contamination. If too many pills pour out, return the pills from the bottle cap into the container.
   - It is a good idea to use a separate disposable paper cup for each medication. Pouring all the medications in one paper cup increases the risk of medication errors.
8. For bubble packs, push all the tablets/capsules from the bubble pack into a small paper cup.
9. For liquid medication, pour the correct dose into the plastic measuring cup held at eye level.
   - View the medication in the cup on a flat surface.
   - Pour away from the medication label to avoid staining it with spills.
   - If any medication spills on the bottle, wipe it away.

   or

   When using a measuring spoon:
   - Locate the marking for the dose.
   - Hold the device at eye level and fill to the correct dosage marking.
   - Pour away from the medication label to avoid spills.
   - If any spills on the bottle, wipe away.

   Additional tips for liquid medication:

   Check the label to see if the bottle needs to be shaken.

Steps for Assisting with Medication (continued)

Use only a calibrated measuring cup or spoon. Regular eating spoons are not accurate enough and should never be used.

If too much liquid is poured, do not pour it back into the bottle—discard it.

Wash the calibrated measuring device and air dry on a paper towel.

10. Talk with the individual you are assisting about what you are doing and about why he or she is taking each medication.
11. Again, just before putting the medication within the individual's reach, read the medication label and compare to the Medication Log for the Five Rights:
    - Right individual
    - Right medication
    - Right dose
    - Right time

    Again, check the time on your watch or clock.
    - Right route
12. Place the medication within the individual's reach.
13. Offer a glass of water (at least four ounces).
    - It is a good idea to suggest to the individual that he tilt his head forward slightly and take a small sip of water before placing the pill in the mouth. Wetting the mouth may make swallowing easier and tilting the head slightly forward (as opposed to throwing it back) may decrease the risk of choking. If pills are not taken with liquids they can irritate the throat and intestinal tract and they may not be correctly absorbed.
    - Some medications must be taken **with food**, and there may be other special instructions. Make sure that you have read any warning labels and are familiar with any special instructions for taking the medication.
14. Make sure that the individual takes the medication and drinks water.
    - Stay with the individual until you are sure that he or she has swallowed the medication.
    - If the individual has difficulty drinking an adequate amount of water or swallowing liquids, the DSP can ask the doctor about the individual taking the medication with:
      – Jell-O that is semi-liquid or jellied or
      – Apple juice or other "medication-compatible" juice thickened with cornstarch or other thickening agent.

    Medications should **never** be disguised by putting them in food or liquid. Tablets should never be crushed unless the prescribing physician gives the specific direction to do so. Capsules should not be opened and their contents emptied out. If the individual has trouble taking a medication, talk to the individual about their needs and preferences and then talk to the doctor about optional ways to take the medication.
15. Record that the individual took his or her medication by initialing the date and time in the proper box on the Medication Log.
16. Return the medication containers and/or bubble pack to the individual's storage unit. As you do so, read the labels to check that the individual's name on the medication container label is the same as the name on the storage unit.

Steps for Assisting with Medication (continued)

Key point:

Never leave the medication container unattended or give to someone else to return to the locked storage container or area.

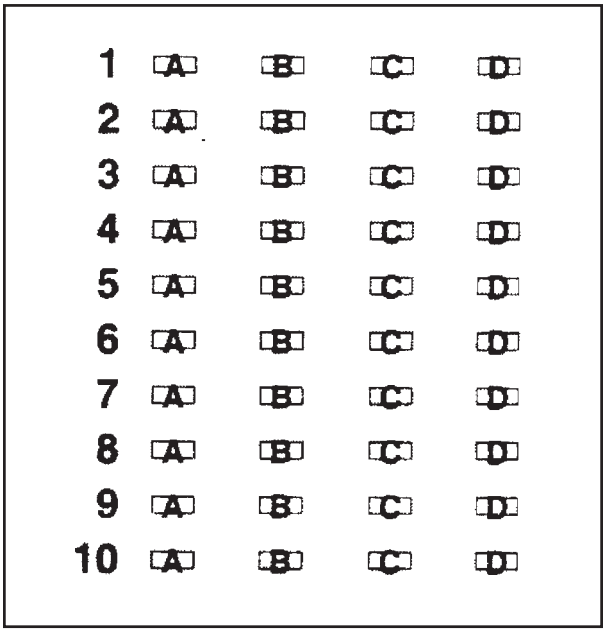
When assisting an individual with other types of medications such as topical creams and ointments, ear drops, nose drops, and eye drops, consult with the prescribing physician and the pharmacist for specific procedures for self-administration of the medication. Also, refer to additional material in Appendix 5-D, 5-E, and 5-F that describe the process for assisting with these types of medications.

IF YOU HAVE ANY DOUBT AS TO WHETHER THE MEDICATION IS IN THE CORRECT FORM AS ORDERED OR THAT YOU CAN ASSIST THE INDIVIDUAL WITH SELF ADMINISTRATION AS DIRECTED ON THE LABEL, CONSULT WITH THE PRESCRIBING DOCTOR OR THE PHARMACIST.

PRACTICE AND SHARE

Think about the individuals you support and the medications they take. Pick one medication and learn about the possible side effects.

Medication Management, Part 1



1. **Community Care Licensing regulations forbid giving any medications to individuals unless ordered or prescribed by a doctor, dentist or a:**
   A) DSP who has successfully completed the two-years of required training.
   B) Facility Administrator.
   C) Nurse Practitioner.
   D) Parent or other close family member.

2. **It is all right for a DSP to dispense OTC medications like vitamin supplements or Tylenol to individuals as long as:**
   A) There is a good chance they will help the person have better health or comfort.
   B) The DSP carefully follows the instructions on the medication label.
   C) A doctor, dentist, or nurse practitioner has prescribed this medication for the person.
   D) A doctor, dentist, or nurse practitioner has not prohibited the use of the medication.

3. **Which one of the following always appears on a pharmacy medication label?**
   A) How long it took the pharmacist to fill the prescription.
   B) The name of the medication in the container.
   C) The names of all other medications the person is taking.
   D) The 911 phone number to call in case of serious side effects.

4. **Which of the following abbreviations means that the medication may be given to the person when it is necessary, or as needed?**
   A) RSVP
   B) PRN
   C) ASAP
   D) OTC

5. **When the right dose of medication is taken, the individual receives the correct:**
   A) Brand name of medication.
   B) Category of medication
   C) Amount of medication.
   D) Side effects of medication.

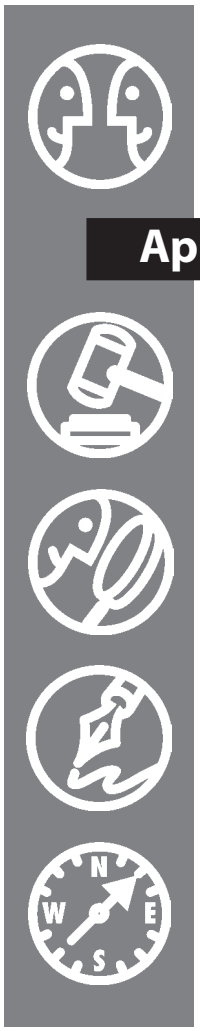
6. **If the doctor changes the dose or time a medication is given to a person, the DSP should always:**
   A) Phone back immediately to make sure the call really came from the doctor.
   B) Write the change down and make an entry on the Medication Administration Sheet or Log.
   C) Wait 24 hours before making the change, to give the person time to adjust.
   D) Call 911 if the DSP thinks the doctor made a mistake.

7. **One good way to learn more about a prescription drug is to:**
   A) Get a copy of the medication information sheet from the pharmacist.
   B) Ask the person taking the medication what they think about it.
   C) Watch the drug company's advertisements on TV.
   D) Take the medication one or two times yourself, to learn firsthand what it does.

8. **Which of the following is one of the "Five Rights" of Medication Administration?**
   A) Right DSP
   B) Right Doctor
   C) Right Time
   D) Right Pharmacy

9. **The DSP assists only one person at a time with self-administration of medications mainly in order to:**
   A) Show the person they are respected as a unique and important individual.
   B) Assure the Five Rights of medication administration are observed.
   C) Keep the work area in a safe and sanitary condition.
   D) Prevent the DSP from experiencing "burn out" and fatigue.

10. **When the DSP is surprised to find that a person's medication dose has increased suddenly, the DSP should:**
    A) Give the person more time and liquid to take the increased dose.
    B) Give the same lower dose that was given before.
    C) Get suspicious and try to learn why this has happenned.
    D) Make sure the other medications are increased as well.



Appendices

Appendix 4-A

Guidelines for Assisting with Self-Administration of Medication

1. There must be a written, dated, and signed **physician's order** in the individual's record **before a DSP can assist** the individual with self-administration of any medication, prescription, or over-the-counter medication.
2. **Only one DSP** should assist an individual with medications at any given time. That DSP should complete the entire process. Never hand a medication to one individual to pass on to another.
3. **Always wash your hands** before assisting an individual with self-administration.
4. The DSP should **always prepare medication in a clean, well-lit, quiet area.** Allow plenty of time, avoid rushing, and stay focused. Check the Five Rights by reading the Medication Label and comparing to the Medication Log three times before the individual takes the medication.
5. **To avoid errors, it is recommended that the medications be set up immediately before assisting an individual with self-administration of medications.** While Community Care Licensing regulations permit the set up of medications up to 24 hours in advance, there are many potential problems with this practice, including the possibility of the wrong individual taking the wrong medication and wrong dose at the wrong time.
6. **DSPs should ask for help from the prescibing doctor or pharmacist** if he or she is unsure about any step in the preparation of, assistance with, or documention of medications.
7. **Medication should never be disguised** by putting it in food or liquid.
8. **The DSP should always ask the physician (and pharmacist) to give the medicine in the proper form for the individual based on the individual's needs and preferences.**

   For example, one individual may have difficulty swallowing capsules and prefer liquid medication, while another may prefer capsules.
9. **Tablets should never be crushed** unless the prescribing physician has given specific directions to do so. **Capsules should not be opened** and their contents emptied out. Controlled release tablets can deliver dangerous immediate doses if they are crushed. Altering the form of capsules or tablets may have an impact on their effectiveness by changing the way an individual's body absorbs them.
10. **Read the medicine warning label, if any. It will give you important information about how the medication should be taken.**

ASK! ASK! ASK!

CHECK! CHECK! CHECK!

Appendix 4-B

Assisting Individuals with Self-Administration of Tablets, Capsules, and Liquid Medications

SKILL CHECK #1

Directions

Partner with another member of the class. Each partner should have a Skill Check #1 Worksheet. Using the Worksheet, practice all the steps in this skill. Have your partner check off each step you correctly complete (PARTNER CHECK). When you are comfortable that you are able to correctly complete all the steps without using the Worksheet, ask the teacher to complete the Teacher Check.

Reminders for Assisting With Self-Administration

- **Always** store medication in a locked cabinet and/or refrigerator.
- **Never** leave medication unattended once it has been removed from the locked storage area.
- **Always** check for known allergies.
- **Always** read the medication label carefully and note any warning labels.
- Assist only with medication from labeled containers.
- Assist only with medication that you have prepared.

HELPFUL HINT

- When completing this skill check, remember that you are checking the **Five Rights three times** by reading the medication label and comparing it to the Medication Log.
- The first check is when you remove the medication from the locked storage area or storage container.
- The second check is when you remove the medication from its original labeled container.
- The third check is just before you assist the individual with self-administration.

COMPETENCY: Each student is required to complete Skill Check #1 Worksheet, Assisting Individuals With Self-Administration of Tablets, Capsules, and Liquid Medications, with no errors.

_____

TEACHER

_____

STUDENT

_____

DATE

Assisting Individuals with Self-Administration of Tablets, Capsules, and Liquid Medications

Scenario: The time is 8:00 a.m. The date is the day of the class. The DSP is assisting Jacob Smith with self-administration of medication.

Please initial each step when completed correctly

STEPS	Partner Check	Teacher Check: Attempt #1 Date	Attempt #2 Date	Attempt #3 Date
1. Help the individual whom you are assisting to wash his or her hands.				
2. Wash your hands.				
3. Get the Medication Log for the individual you are assisting.				
4. Gather supplies:				
▸ The labeled medication storage unit with the medication containers				
▸ Paper cups for tablets and capsules, plastic calibrated measuring cup, or medication spoon for liquid				
▸ Glass of water				
▸ Tissues				
▸ Pen				
5. As you take each medication container from the individual's storage unit, read the medication label and compare to the Medication Log for the:				
▸ Right individual				
▸ Right medication				
▸ Right dose				
▸ Right time (check the time on your watch orclock)				
▸ Right route				

Assisting Individuals with Self-Administration of Tablets, Capsules, and Liquid Medications

	Please initial each step when completed correctly			
		Teacher Check		
STEPS	Partner Check	Attempt #1 Date	Attempt #2 Date	Attempt #3 Date
6. Again, as you prepare the medications, read the medication label and compare to the Medication Log for the:				
▸ Right individual				
▸ Right medication				
▸ Right dose				
▸ Right time (check the time on your watch/clock)				
▸ Right route				
7. For tablets or capsules, pour the correct dose into the lid of the container and then into a small paper cup.				
8. For bubble packs, push tablets/capsules from the bubble pack into a small paper cup.				
9. For liquid medication, pour the correct dose into the plastic measuring cup held at eye level.				
▸ View the medication in the cup on a flat surface.				
▸ Pour away from the medication label to avoid spills.				
▸ If any spills on the bottle, wipe away.				
or				
When using a measuring spoon:				
▸ Locate the marking for the dose.				
▸ Hold the device at eye level and fill to the correct dosage marking.				
▸ Pour away from the medication label to avoid spills.				
▸ If any spills on the bottle, wipe away				

Assisting Individuals with Self-Administration of Tablets, Capsules, and Liquid Medications

STEPS	*Please initial each step when completed correctly*			
		Teacher Check		
	Partner Check	Attempt #1 Date	Attempt #2 Date	Attempt #3 Date
10. Talk with the individual you are assisting about what you are doing and about why he or she is taking each medication.				
11. Again, just before putting the medication within the individual's reach, read the medication label and compare to the Medication Log for the:				
▸ Right individual				
▸ Right medication				
▸ Right dose				
▸ Right time (check the time on your watch/clock)				
▸ Right route				
12. Place the medication within the individual's reach.				
13. Offer a glass of water.				
14. Make sure that the individual takes the medication and drinks water.				
15. Record that the individual took his or her medication by initialing the date and time in the proper box on the Medication Log.				
16. Return the medication containers and bubble pack to the individual's storage unit. As you do so, read the labels to check that the individual's name on the medication container label is the same as the name on the storage unit.				

Certification

This is to certify that

_____

(Name of student)

correctly completed all of the steps for Assisting Individuals with Self-Administration of Tablets, Capsules, and Liquids.

_____

Teacher Signature Date

*Comments*_____

_____

_____

_____

_____

When Assisting with Self-Administration of Medications, You Must Ensure That:

- The Right person
- Receives the Right medication...
- In the Right dose...
- At the Right time...
- By the Right route...

Medication Log

Molina Family Home | 123 Main Street, Any City, CA 90000 | (123) 456-7890

Facility Name | Address | Phone Number

Name: Jacob Smith Insurance: ☑ Medi-Cal ☐ Medicare ☐ Insurance No. 000111

Month & Year (MM/YY) June 04 & Date

Drug/Strength/Form/Dose	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ABC Pharmacy 1017 25th St., Sacramento, CA Phone 123-456-0789 Fax 123-456-0780 Rx: 10387 Dr. Diaz Patient: Jacob Smith 6/15/05 Tegretol 400 mg #30 tablets Take 1 tablet orally every AM for seizures (8 am) Expires: 6/02/06 Filled by: BRS Mfg: Many Medications Refills: 2																																
ABC Pharmacy 1017 25th St., Sacramento, CA Phone 123-456-0789 Fax 123-456-0780 Rx: 10484 Dr. Anderson Patient: Jacob Smith 6/04/05 Amoxicillin 250 mg #30 capsules Take 1 tablet orally every 8 hours for 10 days for bronchitis (8 am, 4pm, 12 am) Expires: 7/01/06 Filled by: BRS 1 Mfg: Many Medications Refills: 0																																
ABC Pharmacy 1017 25th St., Sacramento, CA Phone: 000-000-0000 Fax: 000-000-0000 Rx: 10484 Dr. Anderson Patient: Jacob Smith 06/04/05 Liquid: TAKE 5cc EVERY SIX HOURS FOR COUGH (2AM, 8AM, 2PM, 8PM) Discard by: 07/01/06 Filled by: BRS QTY: 100CC Refills: 0 RUBYTUSSIN																																

Primary Care Physician: Dr. Diaz Pharmacy: ABC Pharmacy

Staff Signatures & Initials: _____for _____ _____for _____ _____for _____

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies: None

Appendix 4-C

Medication Log

Facility Name _____ Address _____ Phone Number _____

Name: _____ Insurance: ❑ Medi-Cal ❑ Medicare ❑ Insurance No. _____

Drug/Strength/Form/Dose	Hour	Month & Year (MM/YY) _____ & Date _____																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Primary Care Physician: _____ Pharmacy: _____

Staff Signatures & Initials: _____ for _____ _____ for _____ _____ for _____

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies:

Errors and Omissions

Date	Time	Medication Involved	Description of what happened (How discovered, effect upon person, sequence of events and individuals)	Who was notified, e.g. Doctor, Administrator, Emergency Services, etc.	Initials

INSTRUCTIONS FOR USE: Circle the date and time of error or omission on reverse side. Complete report on each error or omission indicated on this page.

Appendix 4-E

COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

Self-Assessment Guide

MEDICATIONS

TECHNICAL SUPPORT PROGRAM

MEDICATIONS

Medication handling represents an area of great responsibility. If not managed properly, medications intended to help a client's/resident's health condition may place that individual's health and safety at risk. The information contained in this handout outlines medication procedures you are required to perform by regulation, as well as some procedures not required by regulation which, if implemented, will provide additional safeguards in the management of medications in your facility. If you operate a Community Care Facility (CCF), the specific medication regulations you must comply with are in section 80075. If you operate a Residential Care Facility for the Elderly (RCFE), the specific medication regulations you must comply with are in section 87575. ***This guide cannot be used as a substitute for having a good working knowledge of all the regulations.***

WHAT YOU (CARE PROVIDERS) SHOULD DO WHEN:

1. Client/resident arrives with medication:

- Contact the physician(s) to ensure that they are aware of all medications currently taken by the client/resident.
- Verify medications that are currently taken by the client/resident and dispensing instructions.
- Inspect containers to ensure the labeling is accurate.
- Log medications accurately on forms for client/resident records. The Centrally Stored Medication and Destruction Record (LIC 622) is available for this purpose.
- Discuss medications with the client/resident or the responsible person/authorized representative.
- Store medications in a locked compartment.

2. Medication is refilled:

- Communicate with the physician or others involved (for example, discuss procedures for payment of medications, who will order the medications, etc. with the responsible person.)
- Never let medications run out unless directed to by the physician.
- Make sure refills are ordered promptly.
- Inspect containers to ensure all information on the label is correct.
- Note any changes in instructions and/or medication (for example, change in dosage, change to generic brand, etc.)
- Log medication when received on the LIC 622.
- Discuss any changes in medications with the client/resident, responsible person/authorized representative and appropriate staff.

3. A dosage is changed between refills:

- Confirm with the physician. Obtain written documentation of the change from the physician or document the date, time, and person talked to in client's/resident's record.
- Prescription labels cannot be altered by facility staff.
- Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the change.

- Discuss the change with client/resident and/or responsible person/authorized representative.

4. Medication is permanently discontinued:
- Confirm with the physician. Obtain written documentation of the discontinuation from the physician or document the date, time, and person talked to in client's/resident's record.
- Discuss the discontinuation with the client/resident and/or responsible person/authorized representative.
- Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation.
- Destroy the medications. Medication must be destroyed by the facility administrator or designee and one other adult who is not a client/resident. (See destruction requirements for pre-packaged medications in section #17.)
- Sign the medication destruction record/log. (The reverse side of LIC 622, Centrally Stored Medication Record, may be used for this purpose.)

5. Medications are temporarily discontinued ("dc") and/or placed on hold:
- Medications temporarily discontinued by the physician may be held by the facility.
- Discuss the change with client/resident and/or responsible person/authorized representative.
- Obtain a written order from the physician to HOLD the medication, or document in the client's/resident's file the date, time, and name of person talked to regarding the HOLD order.
- Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation and restart date.
- Without altering the label, mark or identify in a consistent manner medication containers that have HOLD orders.
- Be sure to contact the physician after the discontinuation/hold order expires to receive new instructions regarding the use of the medication.

6. Medication reaches expiration date:
- Check containers regularly for expiration dates.
- Communicate with physician and pharmacy promptly if a medication expires.
- Do not use expired medications. Obtain a refill as soon as possible if needed.
- Over-the-counter medications and ointments also have expiration dates (for ointments the expiration date is usually at the bottom of the tube).
- Destroy expired medications according to regulations.
- Log/record the destruction of prescription medications as required. The LIC 622 may be used for this purpose.

7. Client/resident transfers, dies, or leaves medication behind:
- All medications, including over-the-counters, should go with client/resident when possible.
- If the client/resident dies, prescription medications must be destroyed.
- Log/record the destruction as required. The LIC 622 may be used for this purpose.
- Document when medication is transferred with the client/resident. Obtain the signature of the person accepting the medications (i.e., responsible person/authorized representative).
- Maintain medication records for at least 3 years (RCFE) section 87575 (h)(6),(i) or 1 year (CCF) section 80075 (n)(7),(o).

8. Client/resident missed or refused medications:
- No client/resident can be forced to take any medication.
- Missed/refused medications must be documented in the client's/resident's medication record and the prescribing physician contacted immediately.
- Notify the responsible person/authorized representative.
- Refusal of medications may indicate changes in the client/resident that require a reassessment of his/her needs. Continued refusal of medications may require the client's/resident's relocation from the facility.

9. Medications need to be crushed or altered:

- Medications may be crushed or altered to enhance swallowing or taste, but never to disguise or "slip" them to a client/resident without his or her knowledge.
- The following written documentation must be in the client's/resident's file if the medication is to be crushed or altered:
  1. A physician's order specifying the name and dosage of the medication to be crushed;
  2. Verification of consultation with a pharmacist or physician that the medication can be safely crushed, identification of foods and liquids that can be mixed with the medications, and instructions for crushing or mixing medications;
  3. A form consenting to crushing the medication signed by the client/resident. If the client/resident has a conservator with authority over his/her medical decisions, the consent form must be signed by that conservator.

10. Medications are PRN or "as needed": Facility staff may assist the client/resident with self-administration of his/her prescription and nonprescription PRN medication, when:

- The client's/resident's physician has stated in writing that the client/resident can determine and clearly communicate his/her need for a prescription or nonprescription PRN medication.
  - The physician provides a signed, dated, written order for the medication on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.
  - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription labels display this information.
- Facility staff may also assist the client/resident with self-administration of his/her **nonprescription** PRN medication if the client/resident cannot determine his/her need for a nonprescription PRN medication, but can communicate his/her symptoms clearly, when:
  - The client's/resident's physician has stated in writing that the client/resident cannot determine his/her need for nonprescription medication, but can communicate his/her symptoms clearly.
  - The client's/resident's physician provides a signed, dated, written order on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.
- The written order identifies the name of the client/resident, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for re-evaluation.
  - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription medication labels display this information.
  - A record of each dose is maintained in the client's/resident's record and includes the date, time, and dosage taken, and the client's/resident's response.
- Facility staff may also assist the client/resident with self-administration of his/her **prescription or nonprescription** PRN medication if the client/resident cannot determine his/her need for a prescription or nonprescription PRN medication, and cannot communicate his/her symptoms when:
  - Facility staff contact the client's/resident's physician before giving each dose, describe the client's/resident's symptoms, and receive permission to give the client/resident each dose.
  - The date and time of each contact with the physician and the physician's directions are documented and maintained in the client's/resident's facility record.

  - The physician provides a signed, dated, written order on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.
  - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period.
  - A record of each dose is maintained in the client's/resident's records and includes the date, time, and dosage taken, and the client's/resident's response.
- SMALL FAMILY HOMES AND CERTIFIED FAMILY HOMES

  Small Family Home staff may assist a child with **prescription or nonprescription** PRN medication without contacting the child's physician before each dose if the child cannot determine and/or communicate his/her need for a prescription or nonprescription PRN medication when (section 83075(d)):
  - The child's physician has recommended or prescribed the medication and provided written instructions for its use on a prescription blank or the physician's letterhead.
  - Written instructions include the name of the child, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for re-evaluation.
  - The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses allowed in a 24-hour period. Most nonprescription medication labels display this information.
  - The date, time, and content of the physician contact made to obtain the required information is documented and maintained in the child's file.
  - The date, time, dosage taken, symptoms for which the PRN medication was given and the child's response are documented and maintained in the child's records.

11. Medications are injectables:

- Injections can ONLY be administered by the client/resident or by a licensed medical professional. Licensed medical professional includes Doctors of Medicine (M.D.), Registered Nurses (R.N.), and Licensed Vocational Nurses (L.V.N.) or a Psychiatric Technician (P.T.). P.T.s can only administer subcutaneous and intramuscular injections to clients/residents with developmental or mental disabilities and in accordance with a physician's order.
- Family members are not allowed to draw up or administer injections in CCFs or RCFEs unless they are licensed medical professionals.
- Facility personnel who are not licensed medical professionals cannot draw up or administer injections in CCFs or RCFEs.
- Licensed medical professionals may not administer medications/insulin injections that have been pre-drawn by another licensed medical professional.
- Injections administered by a licensed medical professional must be provided in accordance with the physician's orders.
- The physician's medical assessment must contain documentation of the need for injected medication.
- If the client/resident does administer his/her own injections, physician verification of the client's/resident's ability to do so must be in the file.
- Sufficient amounts of medications, test equipment, syringes, needles, and other supplies must be maintained in the facility and stored properly.
- Syringes and needles should be disposed of in a "container for sharps", and the container must be kept inaccessible to clients/residents (locked).
- Only the client/resident or the licensed medical professional can mix medications to be injected or fill the syringe with the prescribed dose.

- Insulin and other injectable medications must be kept in the original containers until the prescribed single dose is measured into a syringe for immediate injection.
- Insulin or other injectable medications may be packaged in pre-measured doses in individual syringes prepared by a pharmacist or the manufacturer.
- Syringes may be pre-filled under the following circumstances:
  - Clients of Adult Residential, Social Rehabilitation, Adult Day and Adult Day Support Centers can self-administer pre-filled syringes prepared by a registered nurse, pharmacist or drug manufacturer.
  - Residential Care Facilities for the Elderly, Group Homes and Small Family Homes must obtain exceptions from the licensing office for clients/residents to use pre-filled syringes prepared by a registered nurse.
  - The registered nurse (R.N.) must not set up insulin syringes for more than seven days in advance.
- Injectable medications that require refrigeration must be kept locked.

12. Over-the-counter (OTC) medications, including herbal remedies, are present:
- OTC medications (e.g., aspirin, cold medications, etc.) can be dangerous.
- They must be centrally stored to the same extent that prescription medications are centrally stored (see criteria for central storage in section 80075 (m) for CCFs and section 87575 (h) for RCFEs.)
- Over-the-counter medication(s) that are given on a PRN basis must meet all PRN requirements. (See section #10)
- Physicians must approve the use of all OTC medications that are or may be taken by the client/resident on a regular basis (e.g., aspirin for heart condition, vitamins, etc.) as well as those used on a PRN basis.
- Client's/resident's name should be on the over-the-counter medication container when: (1) it is purchased for that individual's sole use; (2) it is purchased by client's/resident's family or (3) the client's/resident's personal funds were used to purchase the medication.

13. You "set up" or "pour" medications:
- Have clean, sanitary conditions. (i.e., containers, counting trays, pill cutters, pill crushers and storage/setup areas.)
- Pour medications from the bottle to the individual client's/resident's cup/utensil to avoid touching or contaminating medication.
- Medications must be stored in their original containers and not transferred between containers.
- The name of the client/resident should be on each cup/utensil used in the distribution of medications.
- Have written procedures for situations such as spillage, contamination, assisting with liquid medication, interactions of medications, etc.
- Have written procedures for facility staff regarding assisting with administration of medication, required documentation, and destruction procedures.

14. Assisting with medications (passing):
- Staff dispensing medications need to ensure that the client/resident actually swallows the medication (not "cheeking" the medication); mouth checks are an option for staff.
- Cups or envelopes containing medications should not be left unattended in the dining room, bathrooms, bedrooms or anywhere in the facility.

15. You designate staff to handle medications:
- Have written policies and procedures.
- Train all staff who will be responsible for medications.
- Ensure that staff know what they are expected to do (i.e., keys, storage, set up, clean-up, documentation, notification, etc.).
- Ensure designated staff know what procedures can and cannot be done (i.e., injections, enemas, suppositories, etc.).

16. Medications are received or destroyed:
- Every prescription medication that is centrally stored or destroyed in the facility must be logged.
- A record of prescription medications that are disposed of in the facility must be maintained for at least 3 years in a Residen-

tial Care Facility for the Elderly and 1 year in a Community Care Facility (Group Homes, Adult Residential Facilities, etc.).
- A record of centrally stored medications for each client/resident must be maintained for at least 1 year.

17. Medications are prepackaged:
- Prepackaged medications (bubble packs, trays, cassettes, etc.) are allowed if they are packed and labeled by a pharmacy.
- Licensees and/or facility staff cannot remove discontinued medications from customized medication packages.
- Multi-dose packages must be returned to the pharmacy for changes in doses or discontinuation of a medication.
- Facilities should have procedures in case one dose is contaminated and must be destroyed.
- Facilities (EXCEPT RCFEs) utilizing prepackaged medications must obtain a waiver from the licensing office if medications are to be returned to the pharmacy for disposal.
- RCFEs do not need to obtain a waiver if the medications are returned to the issuing pharmacy or disposed of according to the approved hospice procedures.

18. Sample medications are used:
- Sample medications may be used if given by the prescribing physician.
- Sample medications must have all the information required on a regular prescription label except pharmacy name and prescription number.

19. Transferring medications for home visits, outings, etc.
- When a client/resident leaves the facility for a short period of time during which only one dose of medication is needed, the facility may give the medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, client's/resident's name, name of medication(s), and instructions for administering the dose.
- If client/resident is to be gone for more than one dosage period, the facility may:
  a. Give the full prescription container to the client/resident, or responsible person/authorized representative, or
  b. Have the pharmacy either fill a separate prescription or separate the existing prescription into two bottles, or
  c. Have the client's/resident's family obtain a separate supply of the medication for use when the client/resident visits the family.
- If it is not safe to give the medications to the client/resident, the medications must be entrusted to the person who is escorting the client/resident off the facility premises.
- If medications are being sent with the client/resident off the facility premises, check the Physician's Report (LIC 602 or 602a) to ensure that they are given only to clients/residents whose doctors have indicated that they may control their own medications.
- Always have the person entrusted with the medications sign a receipt which identifies the number and type of medications sent out and returned.

20. House medications/stock supplies of over-the-counter medications are used:
- Centrally stored, stock supplies of over-the-counter medications may be used in CCFs and in RCFEs.
- Licensees cannot require clients/residents to use or purchase house supply medications.
- Clients/residents may use personal funds to purchase individual doses of OTC medications from the licensee's stock if each dose is sold at the licensee's cost and accurate written records are maintained of each transaction.
- All regulations regarding the use of OTC medications must be followed (see section #12).
- Be sure to verify that the client's/resident's physician has approved the use of the OTC before giving him/her a dose from the house supply.

21. Clients/residents use emergency medication(s) (e.g., nitroglycerin, inhaler, etc.):

Clients/residents who have a medical condition requiring the immediate availability of emergency medication may maintain the medication in their possession if all of the following conditions are met:

- The physician has ordered the PRN medication, and has determined and documented in writing that the client/resident is capable of determining his/her need for a dosage of the medication and that possession of the medication by the client/resident is safe.
- This determination by the physician is maintained in the individual's file and available for inspection by Licensing.
- The physician's determination clearly indicates the dosage and quantity of medication that should be maintained by the client/resident.
- Neither the facility administrator nor the Department has determined that the medications must be centrally stored in the facility due to risks to others or other specified reasons. If the physician has determined it is necessary for a client/resident to have medication immediately available in an emergency but has also determined that possession of the medication by the client/resident is dangerous, then that client/resident may be inappropriately placed and may require a higher level of care.

22. Blood pressure and pulse readings are taken:

The following persons are allowed to take blood pressure and pulse readings to determine the need for medications:

- The client/resident when his/her physician has stated in writing that the client/resident is physically and mentally capable of performing the procedure.
- A physician or registered nurse.
- A licensed vocational nurse under the direction of a registered nurse or physician.
- A psychiatric technician under the direction of a physician, surgeon, psychiatrist, or registered nurse. Psych Techs may take blood pressure and pulse readings of clients/residents in any community care licensed facility. The Psych Tech injection restrictions noted in section #11 do not apply to taking vital signs.

The licensee must ensure that the following items are documented when the client's/resident's vital signs are taken to determine the need for administration of medications:

- The name of the skilled professional who takes the reading.
- The date and time and name of the person who gave the medication.
- The client's/resident's response to the medication.

Lay staff may perform vital sign readings as long as the readings are not used to determine a need for medication.

23. Clients/residents need assistance with the administration of ear, nose and eye drops:

- The client/resident must be unable to self-administer his/her own eye, ear or nose drops due to tremors, failing eyesight or other similar conditions.
- The client's/resident's condition must be chronic and resistant to sudden change (stable), or temporary in nature and expected to return to a condition normal for the client/resident.
- The client's/resident's Needs and Services Plan (CCF), Pre-Admission Appraisal (RCFE) or Individual Services Plan (RCF-CI) must state that he/she cannot self administer his/her own drops and specify how staff will handle the situation.
- The client's/resident's physician must document in writing the reasons that the client/resident cannot self-administer the drops, the stability of the medical condition and must provide authorization for the staff to be trained to assist the client/resident.
- Staff providing the client/resident with assistance must be trained by a licensed professional and names of trained staff must be maintained in the staff files. This training must be completed prior to providing the service, must include hands-on instruction in general and client/resident specific procedures, and must be reviewed and updated by the licensed professional at least annually or more often if the condition changes.

- Staff must be trained by a licensed professional to recognize objective symptoms observable by a lay person and to respond to the client's/resident's health problem.
- Staff must be trained in and follow universal precautions and any other procedures recommended by the licensed professional.
- Written documentation outlining the procedures to be used in assisting the client/resident with the drops and all aspects of care to be performed by the licensed professional and facility staff must be maintained in the client's/resident's file. Prior to providing ongoing client/resident assistance with drops, facility staff should consider the use of assistive devices, such as an eye cup, which would enable the client/resident to self-administer the drops.

24. Medications need to be stored:

- All medications, including over-the-counters, must be locked at all times.
- All medications must be stored in accordance with label instructions (refrigerate, room temperature, out of direct sunlight, etc.).
- Medication in refrigerators needs to be locked in a receptacle, drawer, or container, separate from food items. (Caution should be used in selecting storage containers as metal may rust.)
- If one client/resident is allowed to keep his/her own medications, the medications need to be locked to prevent access by other clients/residents.

25. Miscellaneous:

- Medications are one of the most potentially dangerous aspects of providing care and supervision.
- Educate yourself and staff (signs, symptoms, side effects).
- Train staff.
- Develop a plan to evaluate staff's ability to comply with the facility's medication procedures.
- Communicate with physicians, pharmacists, and appropriately skilled professionals.
- Develop a system to communicate changes in client/resident medications to staff and to the client/resident.
- Staff should be trained on universal precautions to prevent contamination and the spread of disease.
- Document.
- Know your clients/residents.
- Be careful.

Appendix 4-F

Amoxicillin Information Sheet

Brand name: Amoxil; Biomox; Polymox; Trimox; Wymox

Why is this medication prescribed?
Amoxicillin is a penicillin-like antibiotic used to treat certain infections caused by bacteria, such as pneumonia; bronchitis; venereal disease (VD); and ear, lung, nose, urinary tract, and skin infections. It also is used before some surgery or dental work to prevent infection. Antibiotics will not work for colds, flu, or other viral infections. This medication is sometimes prescribed for other uses; ask your doctor or pharmacist for more information.

How should this medicine be used?
Amoxicillin comes as a capsule, chewable tablet, liquid, and pediatric drop to take by mouth. It is usually taken every 8 hours (three times a day). Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take amoxicillin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Shake the liquid and pediatric drops well before each use to mix the medication evenly. Use the bottle dropper to measure the dose of pediatric drops. The pediatric drops and liquid may be placed on a child's tongue or added to formula, milk, fruit juice, water, ginger ale, or other cold liquid and taken immediately.

The tablets should be crushed or chewed thoroughly before they are swallowed. The capsules should be swallowed whole and taken with a full glass of water.

Continue to take amoxicillin even if you feel well. Do not stop taking amoxicillin without talking to your doctor.

What special precautions should I follow?
Before taking amoxicillin,
- tell your doctor and pharmacist if you are allergic to amoxicillin, penicillin, or any other drugs.
- tell your doctor and pharmacist what prescription and nonprescription medications you are taking, especially other antibiotics, allopurinol (Lopurin), anticoagulants ('blood thinners') such as warfarin (Coumadin), oral contraceptives, probenecid (Benemid), and vitamins.
- tell your doctor if you have or have ever had kidney or liver disease, allergies, asthma, blood disease, colitis, stomach problems, or hay fever.
- tell your doctor if you are pregnant, plan to become pregnant, or are breast-feeding. If you become pregnant while taking amoxicillin, call your doctor.
- if you are having surgery, including dental surgery, tell the doctor or dentist that you are taking amoxicillin.

What special dietary instructions should I follow?
Amoxicillin may cause an upset stomach. Take with food or milk.

What should I do if I forget a dose?
Take the missed dose as soon as you remember it. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule. Do not take a double dose to make up for a missed one.

What side effects can this medication cause?
Although side effects from amoxicillin are not common, they can occur. Tell your doctor if any of these symptoms are severe or do not go away:
- upset stomach
- diarrhea
- vomiting
- mild skin rash

If you experience any of the following symptoms, call your doctor immediately:
- severe skin rash
- itching
- hives
- difficulty breathing or swallowing
- wheezing
- vaginal infection

What storage conditions are needed for this medicine?
Keep this medication in the container it came in, tightly closed, and out of reach of children. Store the capsules and tablets at room temperature and away from excess heat and moisture (not in the bathroom). Throw away any medication that is outdated or no longer needed. Keep the liquid medication in the refrigerator, tightly closed, and throw away any unused medication after 14 days. Do not freeze. Talk to your pharmacist about the proper disposal of your medication.

In case of emergency/overdose
In case of overdose, call your local poison control center at 1-800-222-1222. If the victim has collapsed or is not breathing, call local emergency services at 911.

What other information should I know?
Keep all appointments with your doctor and the laboratory. Your doctor will order certain lab tests to check your response to amoxicillin.

If you are diabetic, use Clinistix or TesTape (not Clinitest) to test your urine for sugar while taking this drug.

Do not let anyone else take your medication. Your prescription is probably not refillable. If you still have symptoms of infection after you finish the amoxicillin, call your doctor.

Last Revised - 01/01/2003

Appendix 4-G

Medication Safety Questionnaire

Name			
Brand:_____ Generic:_____	Dose (e.g., mg) and form (e.g., tabs)	When to take each dose?	For how long?

1. What is the medication supposed to do?

2. How long before I will know it is working or not working?

3. What about serum (blood) levels? Other laboratory work? How often? Where? Standing order?

4. If the individual misses a dose, what should I do?

. . . . . .

INTERACTIONS?

5. Should this medication be taken with food? ☐ Yes ☐ No

   At least one hour before or two hours after a meal? ☐ Yes ☐ No

6. Are there any foods, supplements (such as, herbs, vitamins, minerals), drinks (alcoholic, for example), or activities that should be avoided while taking this medication?

   ☐ Yes (Which ones?) _____

   ☐ No

7. Are there any other prescription or over-the-counter medications that should be avoided?

   ☐ Yes (Which ones?) _____

   ☐ No

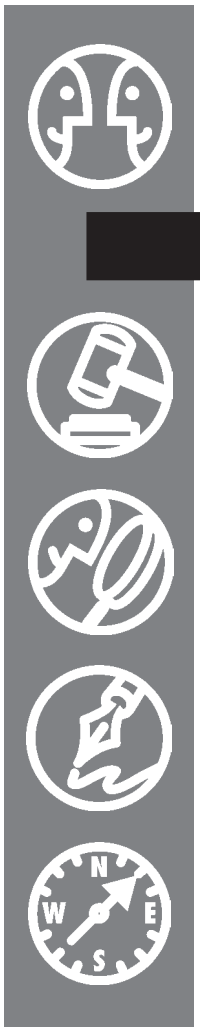
. . . . . .

SIDE EFFECTS? IF SO, RESPONSE?

8. What are common side effects?

9. If there are any side effects, what should I do?

10. If the drug is being prescribed for a long period of time, are there any long-term effects?



Student Resource Guide

5. Medication Management, Part 2

Student Resource Guide: SESSION 5

Medication Management: Part 2

OUTCOMES

When you finish this session, you will be able to:

- Describe Community Care Licensing requirements for handling and storing prescription, over-the-counter, and PRN medications.
- Document medication-related information, including: self-administration, missed doses, errors, side effects, and drug interactions.
- Identify medication side effects and drug interactions.
- Describe required reporting procedures in cases of medication side effects and drug interactions.
- Identify appropriate responses to severe side effects that may be life threatening.
- Identify procedures for destroying medication.
- Describe procedures for packaging medication got self-administration away from the home.

KEY WORDS

Allergic Reaction: A reaction caused by an unusual hypersensitivity to a medication (or insect stings or certain foods).

Medication: Substance taken into the body (or applied to) for the purpose of prevention, treatment, relief of symptoms, or cure.

Medication Error: Any time the right medication is not taken as prescribed.

Medication (Drug) Interactions: The result, either desirable or undesirable, of drugs interacting with themselves, other drugs, foods, alcohol, or other substances, such as herbs or nutrients.

Ophthalmic: Refers to the eyes.

Otic: Refers to the ears.

PRN (*pro re nata*) Medication: An abbreviation that means "as needed." Refers to prescription or over-the-counter (OTC) medication.

Side Effects: Effects produced by medication other than those for which it was prescribed. Sometimes side effects, such as a severe allergic reaction, can be deadly.

Topical: Applied to a certain area of the skin.

Handling Medications in Licensed Care Facilities

In this session you will learn about correct handling, ordering and storing of medications, how to record and report medication errors, recording, and problem-solving when an individual refuses a dose of medication and about PRN medications. You will also learn more about observing, reporting, and recording medication side effects and drug interactions.

Ordering Medications from the Pharmacist

It is essential that medications are ordered from the pharmacist on a regular basis so that the individual always has needed medication. It is a good idea to order refills a week before running out. New medications should be ordered immediately after being prescribed by the doctor.

Some pharmacies provide extra services and package medications in ways that can be helpful, such as bubble packs. Prepackaged bubble packs are popular, but it is essential for the DSP to understand how to use them.

Storage

Community Care Licensing regulations require that all medications entering the home be logged in a Centrally Stored Medication and Destruction Log (Appendix 5-A). A centrally stored record of medications for each individual must be maintained for at least one year.

All medication in a licensed community care facility home must be centrally stored in locked cabinets or drawers, unless ordered otherwise. The medication storage area should provide an environment that is cool, dry, and away from direct sunlight.

If a centrally stored medication requires refrigeration, it must be in a locked container. It is recommended that you use a thermometer and keep the refrigerator in the 36–40 degree range.

If an individual takes medication without assistance, the medication must be locked in a secure place, like a bedside drawer, in the individual's room.

Destruction

If a medication is discontinued by the doctor or is past the expiration date on the label, or if a person leaves the home and does not take his or her medicine to the new residence, the medication must be returned to the pharmacy or destroyed by the facility administrator or designee in the presence of another adult who is not a resident. Multidose packages must be returned to the pharmacy when a medication is discontinued. Document disposition of medications on the Medication Log and on the Medication Destruction Log required by Community Care Licensing.

Each facility should have a written procedure for the destruction of medication. You may consult the dispensing pharmacy for the proper method of destruction.

PRN Medications

PRN means the medication is taken "as needed" to treat a specific symptom. PRN medications include both prescription and over-the-counter medications. PRN medications must always be ordered by a doctor. Community Care Licensing has established specific requirements for staff to assist individuals with self-administration of PRN medications.

Community Care Licensing Requirements for PRN Medications for Children and Adults

In CCFs, how PRN medications are handled depends upon the individual's needs and the type of facility. For every **prescription and over-the-counter (non-prescription) PRN medication** for which the DSP provides assistance there must be a signed, dated written order from a doctor, on a prescription blank, maintained in the individual's record, and a label on the medication. Both the doctor's order and the label shall contain at least all of the following information:

- Individual's name
- Name of the medication
- The specific symptoms that indicate the need for the use of the medication.
- The exact dosage.
- The minimum number of hours between doses.
- The maximum number of doses allowed in each 24-hour period.

Each dose of PRN medication should be recorded on the individual's Medication Log.

Additional Requirements for Assisting Adults with PRN Medication

In an adult residential facility:

1. The DSP may assist an individual with self administration of his or her **prescription or over-the-counter PRN** medication when the doctor has stated in writing the individual is able to determine and clearly communicate his or her need for the PRN medication. The doctor's signed, dated statement must be kept in the individual's record.

2. The DSP may assist an individual with self administration of his or her **over-the-counter PRN** medication when the doctor had stated in writing that the individual is unable to determine his or her need for the over-the-counter medication, but is able to clearly communicate the symptoms. The doctor's signed, dated statement must be kept in the individual's record.
   - The doctor's written order must also provide instructions regarding when the medication should be stopped, and instructions for when the doctor should be contacted for reevaluation.
   - A record of each dose, including the date, time, and dosage taken, and the individual's response, must be kept in the individual's record.

3. DSPs designated by the administrator may assist an individual with self administration of his or her **prescription or over-the-counter PRN** medication when the individual is unable to clearly communicate his or her symptoms.
   - Before assisting with each dose, the DSP must contact the individual's doctor, describe the symptoms and get directions for assisting the individual. The DSP must write the date and time of each contact with the doctor, the doctor's directions, and maintain this information in the individual's record.
   - A record of each dose, including the date, time and dosage taken, and the individual's response, must be kept in the individual's record.

Additional Requirements for Assisting Children With PRN Medications

In a small family home for children the DSP may assist a child with a **prescription or over-the-counter PRN** medication without contacting the doctor before each dose when the child is unable to determine and/or communicate his of her need for the PRN medication when:

- In addition to the information on the doctor's order and the medication label required for all CCFs, the doctor's written order for children in a small family home must also provide instructions regarding when the medication should be stopped, and instructions for when the doctor should be contacted for reevaluation.
- The medication must be given in accordance with the written doctor's order.
- A record of each dose, including the date, time and dosage taken, and the individual's response, must be kept in the individual's record.

Remember: For both children and adults, for every PRN medication for which the DSP provides assistance there must be a signed, dated written order from a doctor, on a prescription blank, maintained in the individual's record, and a label on the medication.

Refusal of Medications

An individual has the right to refuse his or her medication. It is the DSP's responsibility to work with and support the individual in taking his or her medicine. If an individual refuses to take the medication, ask "Why?" Do not try to crush or hide the medication in the individual's food to get him or her to take the medicine.

Reasons for Medication Refusal and Possible Helpful Suggestions

The following is a list of some common reasons an individual might refuse to take his or her medication and suggestions on how to provide assistance.

Unpleasant Taste

- Give the individual ice chips to suck on just before taking the medication. This will often help mask the bad taste.
- Ask the doctor or pharmacist if the medication can be diluted to cover a bad taste. Ask the physician or pharmacist if there is a juice compatible with the medication that can be used (for example, apple juice). A note to this effect should be on the prescription label.
- Provide crackers, apple, or juices afterwards to help cover up the bad taste.

Unpleasant Side Effect - Drowsiness

Report the unpleasant side effect and ask the prescribing doctor if the individual can take the medication at a different time (such as before bedtime). Also ask about changing the medication or treating the side effect.

Lack of Understanding

Provide simple reminders on what the name of the medication is and what the medication does. For example, "This is Depekene medication that stops your seizures."

Denial of Need for Medication

Discuss the need for the medication, but do not argue. It may help to show the individual a statement written by the physician; for example, "Alma, you take your heart medication everyday."

Documenting and Reporting

Medication refusal needs to be documented on the medication record and brought to the attention of the prescribing doctor. The doctor may be able to accommodate an individual's medication preference or special health consideration. Any unused dose should be set aside and destroyed in an acceptable way.

Packaging of Medications for Dose Away from Home

The DSP may package a single dose of each medication needed for no more than a day to be taken at work, a day program, or elsewhere, such as on a home visit. With the doctor's written approval, the medication can be carried by the individual who will take it. Otherwise, the medication is to be given to a responsible party in an envelope (or similar container) labeled with:

- The facility's name, address, and phone number.
- The individual's name.
- Name of the medication(s).
- Instructions for assisting with self-administration of the dose.

If an individual is regularly taking a dose of medication at school or at a day program, tell the physician and pharmacist. The doctor may order a separate prescription for a particular dose of medication.

Medication Errors

Every medication error is serious and could be life threatening. The DSP's job is to safely assist individuals to receive the benefits of medications. Preventing medication errors is a priority. In this training you have learned the best way to help individuals take medication safely and to reduce the risk of errors. But even in the best of situations, errors may occur. When they do, you need to know what to do.

A medication error has occurred when:

- The **wrong** person took the **wrong** medication.
- The **wrong** dosage was taken.
- Medication was taken at the **wrong** time.
- Medication was taken by the **wrong** route.
- Medication was **not** taken.

Every medication error is serious and could be life threatening.

If an error does occur, it must be reported immediately to the prescribing doctor. Follow the doctor's instructions.

The error must be recorded either in the Medication Log (Appendix 5-G) or other document specific to your home. The record should include the date, time, medication involved, description of what happenned, who was notified, doctor's name, instructions given, and action taken.

Any medication errors is a Special Incident that must be reported to Community Care Licensing and the regional center. Follow the procedures for Special Incident reporting outlined in Session 3 and for the home where you work.

Remember, Prevention Is the #1 Priority.

You can prevent errors by:

- Staying alert
- Following the **Five Rights.**
- Avoiding distractions.
- Knowing the individual and his or her medications.
- Asking the administrator for help if you are unsure about any step in preparing, assisting, or documenting medications.

ACTIVITY

Documenting Medication Errors

Read each scenario and identify the error. Describe what action the DSP should take and what actions can prevent this in the future.

Scenario #1

You are working as a DSP on the evening shift. All six individuals living in the home are present. This morning, Ruth Ann Jones, age 55, moved into the home. Ruth Ann is diagnosed with mental retardation, cause unknown. You are assisting with the evening medications, and this is the first time you are assisting Ruth Ann. When you look at the Medication Log, you notice that Ruth Ann takes many medications. These include:

Prilosec 20 mg daily (8 a.m.)
Prozac 20 mg twice daily (8 a.m. and noon)
Haldol 2 mg 3 times a day (8 a.m., 12 p.m., and 5 p.m.)
Inderal 40 mg 3 times a day (8 a.m., 12 p.m., and 5 p.m.)
Peri-Colace 2 capsules at bedtime

You prepare the medications and assist Ruth Ann in taking them. When you sit down to document the medications given, you notice that only two, Haldol and Inderal, were to be given at 5 p.m. You gave the four medications ordered for earlier in the day, which included Prilosec and Prozac, as well as Tegretol and Inderal.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Continued

ACTIVITY

Continued from previous page

Scenario #2

You are a DSP working in a small family home for children under the age of 18. There are six children in your home under the age of 8. You have prepared the medications for Sarah, who is 2 years old. The medications include:

- Proventil syrup 2 mg/5ml, 5ml daily in the morning
- Tegretol 100mg/5ml, 5 ml twice daily
- Cisapride 1mg/1ml, 3 ml four times a day, before meals and before sleep

It is 8 a.m. You help Sarah take 5 ml of each medication. When you document on the Medication Log, you notice the Cisapride was ordered 3 ml four times a day.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Scenario #3

You have prepared morning medications for Guy. Jack calls from another room and wants assistance. You get up and go to the other room. When you return, you see Mike, Guy's roommate, finishing Guy's medication.

What was the error?

What should you do?

What can the DSP do to prevent this from happening again?

Monitoring the Effects of Medication

The unintended effects of medication, called side effects, can occur at any time. Some mild side effects may disappear after a short time. Others will persist the entire time the medication is taken and sometimes beyond. Some side effects are mild while others are life-threatening.

In the home where you work, it is important to learn about the medications each individual is taking. It's also important to know what possible side effects may occur. Be sure to ask the doctor what kind of reactions should be brought immediately to his or her attention.

The pharmacy is a good source for information about the effects of medication. Medication information sheets should come with every new medication. Pharmacists should talk with each individual receiving a new medication (or change in dose), but you may have to ask questions and request written material. Pharmacists are knowledgeable about drugs, side effects, and interactions.

Asking both the doctor and the pharmacist is a good strategy because it takes advantage of two important expert resources within the health care system. It is helpful to write possible side effects in the individual's Medication Log and attach the medication information sheet

Physical and behavioral changes that are due to the effect of a medication are often difficult to identify. There may be many different reasons for the same sign or symptom. A change in behavior may be due to a medication change or a change in the person's environment. A sore throat may be one of the first symptoms of a cold or may be a side effect of a medication.

Your responsibility is to consistently and accurately observe, report, and record any change in

the normal daily routine, behavior, ways of communicating, appearance, physical health, and

general manner or mood of the individual you support. Interpretation (deciding the meaning) of an observed side effect is the

responsibility of the individual's doctor.

Monitoring for the Effects of Medication

- For each individual you support, know the intended and unintended effects of each medication he or she takes.
- Observe for intended and unintended effects of the medication.
- Document what you observe.
- Report observations to the doctor.
- Follow the doctor's directions to continue, change, or discontinue the medication.
- Monitor the individual closely for side effects when a new medication has been prescribed or the dosage increased.

Common Side Effects of Medication that You Should Report to the Doctor Include:

- Skin Rash
- Increased heart rate or feeling like the heart is racing
- Changes in sleep
- Decreased energy
- Sedation
- Changes in weight or eating patterns
- Tremors, shakiness
- Balance problems
- Shuffling when walking

Monitoring the Effects of Medication

- Confusion
- Changes in ability to concentrate
- Hyperactivity
- Abnormal movements (face, tongue, or body)
- Muscle pain
- Stooped posture
- Blank facial expression
- Feeling dizzy or light-headed
- Dry mouth
- Constipation
- Blurred vision
- Diarrhea
- Nausea
- Vomiting
- Increased risk of sunburn

Tardive Dyskinesia

Tardive Dyskinesia (TD) is a potential long-term neurological side effect of antipsychotic medications such as Mellaril, Thorazine, Risperdal, and Zyprexa. Symptoms may include rapid eye blinking, puckering, or chewing motions of the lips and mouth, or facile grimacing. Symptoms may worsen if the medication is not reduced or discontinued. TD can become permanent. Discuss this risk with the psychiatrist or doctor before starting antipsychotic medications. You should monitor individuals for these serious side effects on a regular basis. If any possible side effects are observed, contact the health care provider immediately.

Medication Interactions

Interactions between two or more drugs and interactions between drugs and food and drink may cause adverse reactions or side effects. Who would ever guess that taking your blood pressure medicine with grapefruit juice instead of orange juice could make you sick? Or that licorice could be lethal when eaten with Lanoxin or Lasix? How could cheddar cheese, pepperoni pizza, or pickled herring combined with an antidepressant create a hypertensive crisis? Yet all of these interactions are real and could lead to disaster.

Drug interactions may be between:

- Two or more drugs
- Drugs and food
- Drugs and drink

Drug interactions may also be caused by mixing drugs and alcohol.

Alcohol in combination with any of the following is especially dangerous**:**

- Antianxiety drugs, such as Librium, Valium, or Xanax.
- Antidepressants.
- Antiseizure medicines.
- Antihistamines.
- Ulcer and heartburn drugs such as Zantac and Tagamet.
- Some heart and blood pressure medicines .

Guidelines for Reporting a Suspected Adverse Reaction to Medication

When you suspect that the individual is having an adverse reaction to a medication, urgent medical care may be needed. Report the suspected reaction to the doctor and follow the doctor's advice. When you talk to the doctor, be prepared to give the following information:

- A list of current medications.
- Description of how the individual looks (pale, flushed, tearful, strange facial expression, covered in red spots).
- Description of any changes in individual's behavior or level of activity.
- Description of what the individual says is wrong or is hurting.
- When the symptoms first started.
- Description of any changes in bodily function:

  Is the individual eating or drinking? Does he or she have a good appetite or no appetite? Any nausea, vomiting, loose feces, constipation, problems urinating?
- Describe any recent history of similar symptoms, any recent injury or illness, or any chronic health problem.
- Describe any known food allergies to food or medication.

Severe, Life-Threatening Allergies (Anaphylaxis)

Some individuals have severe allergies to medications, especially penicillin. The **allergic reaction** is sudden and severe and may cause difficulty breathing and a drop in blood pressure (anaphylactic shock). If an individual has had a severe allergic reaction to a medication (or insect stings or food), he or she should wear an identification bracelet that will tell health professionals about the allergy.

Call 911 immediately to get emergency medical care if signs of a severe allergic reaction develop, especially soon after taking a medication. Signs of an allergic reaction include:

- Wheezing or difficulty breathing.
- Swelling around the lips, tongue, or face.
- Skin rash, itching, feeling of warmth, or hives.

Some individuals have a severe allergy to insect stings or certain foods. If an individuals shows any of these same signs of a severe allergic reaction soon after eating a food or being stung by an insect, call 911 immediately to get emergency medical care.

Following Doctor's Orders for Tests

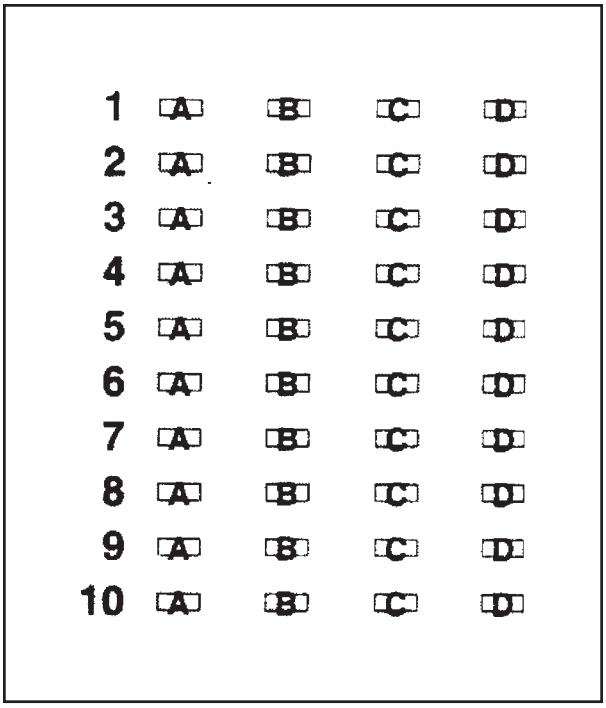
Some medications (Tylenol, Lithium, Depakene) can be toxic and cause damage, especially if taken for a long period of time. Some individuals respond differently to medications; that is, some use and break down medications in their body slower (or faster) than others. For this reason, physicians sometimes start a new medication at low doses and increase it in response to signs of a positive effect such as a reduction in seizures or the development of better sleep patterns.

Checking blood serum levels by analyzing the concentrations of medications in an individual's blood can be important. Physician's orders for lab tests and follow-up appointments must be followed. Blood serum level tests help the physician determine the effectiveness of the medication and the future course of action.

PRACTICE AND SHARE

Talk to your administrator and find out or review what the facility procedures are for documenting medication errors.

Medication Management, Part 2



1. **The "best practice" standard is for the DSP to keep a written record of:**
   A) Every medication dose and every medication error.
   B) The first and last medication doses of each day.
   C) Medication errors that occur two or more times in a 24-hour period.
   D) Medication errors that might easily occur in the near future.

2. **After administering medication to a person, the DSP should:**
   A) Offer a light meal to the person to prevent stomach upset.
   B) Be alert to side effects that may occur.
   C) Check the label to see if this was the proper medication.
   D) Ask the person if they would like a second helping.

3. **Medications can do a lot of good for individuals, but they may also cause:**
   A) Unavoidable confusion for DSPs who have to handle many of them.
   B) Harmful secondary actions or side effects.
   C) Respectful and careful treatment of drugs.
   D) Individuals to have different needs from one another.

4. **When a medication error occurs:**
   A) The error requires Special Incident reporting only if it is life-threatening.
   B) Both 911 and the individual's doctor must be informed of the error.
   C) The error must be reported to the regional center as a Special Incident.
   D) The facility administrator must decide whether a Special Incident Report is needed.

5. **The Medication Log must be updated:**
   A) As soon as a new DSP comes on duty.
   B) Strictly according to the directions found on the medication container label.
   C) Whenever a prescription is changed.
   D) At least one hour before any medication is taken by the person.

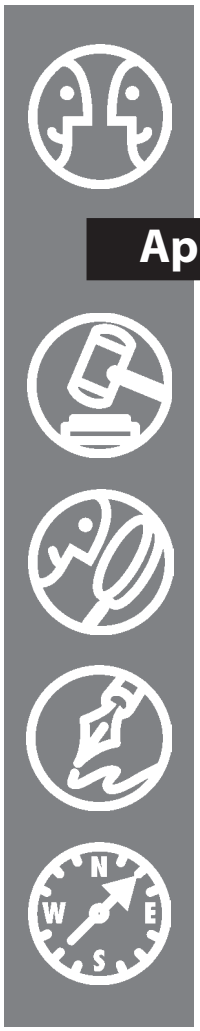
6. **Community Care Licensing regulations require that all drugs in the home must be:**
   A) Kept in a locked refrigerator.
   B) Stored as close as possible to the individual for whom they are prescribed.
   C) Logged in a centrally stored medication record.
   D) Available "over-the-counter" at the pharmacy.

7. **In a licensed residential facility, all medications must be stored:**
   A) In any refrigerator.
   B) On a shelf that no one in the facility can reach without a ladder.
   C) In a locked cabinet or storage area.
   D) Within easy reach of the person for whom they were prescribed.

8. **If a medication is discontinued for an individual, that medication:**
   A) May be destroyed by the facility administrator, while another person watches as a witness.
   B) Should be stored in a locked cabinet until the medication expires (is out of date) and then be used as PRN medication.
   C) May be used by that individual until it is all used up, to avoid waste.
   D) May be used only for another individual who was prescribed the very same medication.

9. **If a medication error results in a serious side effect or life-threatening situation, the DSP should:**
   A) Speak to the individual's doctor over the phone before taking further action.
   B) Immediately call 911 for assistance.
   C) Wait until the individual has difficulty breathing or a high temperature, and then call 911 for assistance,
   D) Call for an emergency meeting of the individual's person-centered planning team.

10. **When packaging a dose of medication for the person to take when away from the facility, the DSP must make sure the following information is written on or contained in the package:**
   A) The person's name and the name of the medication.
   B) The DSP's name and the phone number of the facility.
   C) The doctor's name and the address of the pharmacist.
   D) The "Five Rights."



Appendices

Appendix 5-A

Centrally Stored Medication and Destruction Log

STATE OF CALLIFORNIA HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each client/resident shall be maintained for at least one year.*

FACILITY NAME: Molina Family Home
FACILITY NUMBER:

NAME (LAST): Anthony FIRST: Susan MIDDLE: | ADMISSION DATE: | ATTENDING PHYSICIAN: | ADMINISTRATOR:

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY
Lamictal	25 mg tab /200 tabs		01/02	MM/5	MM/12	Dr. Rodriquez	012346	2	Not given

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *Prescription drugs not taken with the client/resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Administrator or Designated Representative and witnessed by one other adult who is not a client/resident. All facilities except Residential Care Facilities for the Elderly (RCFEs) shall retain destruction records for at least one year. RCFEs shall retain records for at least three years.*

MEDICATION NAME	STRENGTH/ QUANTITY	DATE FILLED	PRESCRIPTION NUMBER	DISPOSAL DATE	NAME OF PHARMACY	SIGNATURE OF ADMINISTRATOR OR DESIGNATED REPRESENTATIVE	SIGNATURE OF WITNESS ADULT NON-CLIENT
Lamictal	25 mg tab /124 tabs	01/02	012346	MM/28	Not given	Juan Molina	Suzy Smith

Appendix 5-B

Common Medication Categories

Drugs are classified into categories with other medications that affect the body in similar ways. Thousands of medications are on the market in many categories. Here is the way the *Nursing Drug Handbook* categorizes medications:

- Anti-infective drugs: antibiotics, antifungals.
- Cardiovascular system drugs: antihypertensives, antiarrhythmics
  - Central nervous system drugs
  - Anticonvulsants, analgesics
  - Sedative-hypnotics
  - Antidepressants, antianxiety
  - Antipsychotics
- Autonomic nervous system drugs: skeletal muscle relaxants, adrenergics.
- Respiratory tract drugs: antihistamines, expectorants.
- Gastrointestinal tract drugs: antacids, antidiarrheals, laxatives.
- Hormonal drugs: estrogens, progestins.
- Antidiabetic drugs: glucagons, thyroid hormones.
- Drugs for fluid and electrolyte balance: diuretics, acidifier, alkalinizers.
- Hematologic drugs anticoagulants.
- Antineoplastic drugs, alkylating drugs, antimetabolites.
- Immunomodulation drugs: vaccines and toxoids; immunosuppressants.
- Ophthalmic, otic, and nasal drugs; ophthalmic anti-inflammatory.
- Topical drugs: corticosteroids, scabicides, anti-infectives.
- Nutritional drugs: vitamins and minerals; calorics.
- Miscellaneous drug categories: antigout drugs; enzymes; gold salts.

Many drugs, because of their multiple uses, can be found in more than one category. For example, Benadryl® is an antihistamine, which relieves allergy symptoms. It's also a sedative to promote sleep.

Appendix 5-C

Community Care Licensing
Incidental Medical Services

Requirements for Health Related Services

By law, CCFs provide non-medical, residential services. Over the years, however, legislative and regulatory changes have permitted certain health-related services to be delivered in CCFs. These exceptions include:

- Hospice care homes for the elderly.
- Certain specialized health care services for medically fragile children.
- Incidental medical care for adults.

It is unlawful for CCFs to accept (or retain) individuals who have certain health care needs that require nursing services.

Individuals with restricted health conditions—for example, who have the need for oxygen or insulin-dependent diabetes—can be served in CCFs if the following standards are met:

- Willingness of the licensee to provide needed care.
- The condition is stable or, if not, temporary and expected to become stable.
- The individual is under the care of a licensed professional.
- A licensed health professional provides training and supervision to unlicensed staff assisting with special or incidental medical care.

Services and supports to children and adults with special or incidental medical care needs are beyond what is covered in this module and will not be discussed further. Staff working in homes that provide special or incidental medical care must be trained and supervised by a licensed health care professional and follow an individual Health Care Plan.

Incidental Medical Services

Prohibited Health Conditions

Individuals who require health services or have the following health conditions cannot be served in community care licensed Adult Residential Facilities (ARFs):

- Naso-gastric and naso-duodenal tubes
- Active, communicable TB
- Conditions that require 24-hour nursing care and or monitoring
- Stage 3 and 4 dermal ulcers
- Any other condition or care requirements which would require the facility to be licensed as a health facility

Restricted Health Conditions

Individuals with the following conditions may be served in an ARF if the requirements for restricted health conditions are met:

- Use of inhalation-assistive devices
- Colostomy or ileostomy
- Requirement for fecal impaction removal, enemas, suppositories
- Use of catheters
- Staph or other serious, communicable infections
- Insulin-dependent diabetes
- Stage 1 or 2 dermal ulcers
- Wounds
- Gastrostomies
- Tracheostomies

Appendix 5-D

Eye Drops

Ophthalmic medications are those put into an individual's eyes.

1. Wash hands.
2. Explain procedure to individual and position him or her, either sitting with head tilted back or lying down.
3. Have a clean separate tissue, gauze, or cotton ball available for each eye.
4. Wipe the lid and eyelashes clean before instillation of the eye drop. Always wipe from inside to outside. Always use fresh gauze or tissue to clean each eyelid.
5. If an eyedropper is used, draw up only the amount of solution needed for administration.
6. Hold the applicator close to the eye, but do not touch eyelids or lashes.
7. Instruct the individual to look up. Place index finger on cheekbone and gently pull lower lid of the eye down to form a pocket.
8. Instill the correct number of medication drops. Avoid dropping medication on the cornea, as this may cause tissue damage and discomfort.
9. Release lower lid and let individual blink to distribute medication.
10. Wipe excess liquid with gauze or clean tissue and make comfortable. Observe.
11. Instruct the individual to keep eye closed for one to two minutes after application to allow for absorption of the medication. Caution the individual not to rub his or her eyes.
12. Recap medication and store bottle away from heat and light in locked medication storage area.

Appendix 5-E

Ear Drops

Otic medications are those put into an individual's ears.

1. Wash hands.
2. Explain to the individual what you are going to do as you warm the drops to body temperature by holding the bottle in your hand for a few minutes before applying.
3. Have the individual lie on his or her side with the ear to be treated facing upward.
4. For adults, pull the cartilaginous part of the external part of the ear up and back. Point the dropper in the direction of the eardrum and allow the drops to fall in the direction of the external canal.
5. For children under 3 years of age, pull the external part of the ear down and back. Point the dropper in the direction of the eardrum and allow the drops to fall on the external canal. Take care not to contaminate the dropper by touching the external ear.
6. Have the individual remain on his or her side for 5 to 10 minutes after administering to allow medication to reach the eardrum and be absorbed.
7. If both ears require medication, leave individual on his or her side for 5 to 10 minutes and then repeat procedure in the other ear. Give individual a tissue but caution him or her not to wipe out medication.
8. Never pack a wick tightly into the ear. On occasion a doctor may pack one in. Special instructions will be given to you if that happens.
9. Recap medication and store bottle away from heat and light in locked medication storage area.

Appendix 5-F

Topical Medications

Topical medications are those applied to an individual's skin or mucous membrane surface.

1. Wash your hands and put gloves on carefully. Provide explanation of procedure to individual. Very frequently, if an individual has a problem requiring topical application of a liquid, cream, or an ointment, the skin will not be intact but will have breaks or sores on the surface.
2. Being mindful of privacy, assist the individual with having the area where the topical medication is to be applied exposed. Make sure clothing and bedding are protected.
3. Open the container and remove just a small quantity of the product to be applied.
4. Apply the lotion or cream with gentle firm strokes. Be sure medication is rubbed in well.
5. Remove gloves carefully and dispose of using standard precautions.
6. Wash hands carefully.
7. Put lid back on container and return to locked storage area.

Medication Log

Facility Name ________ Address ________ Phone Number

Name: ________ Insurance: ❏ Medi-Cal ❏ Medicare ❏ Insurance No.________

Drug/Strength/Form/Dose	Hour	Month & Year (MM/YY) ________ & Date________																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Primary Care Physician: ________ Pharmacy: ________

Staff Signatures & Initials: ________for ________ ________for ________ ________for ________

notes: • *Staff initials date and time medication is taken*
• *If medication is taken at another location, use:*
D= Day Program R= Relative or friend's home E= Elsewhere

Allergies:

Errors and Omissions

Date	Time	Medication Involved	Description of what happened (How discovered, effect upon person, sequence of events and individuals)	Who was notified, e.g. Doctor, Administrator, Emergency Services, etc.	Initials

INSTRUCTIONS FOR USE: Circle the date and time of error or omission on reverse side. Complete report on each error or omission indicated on this page.

Student Resource Guide

6. Wellness: Maintaining the Best Possible Health

Student Resource Guide: SESSION 6

Wellness: Maintaining the Best Possible Health

OUTCOMES

When you finish this session you will be able to:

- Describe the basic concepts of health and wellness.
- Identify key information in a physician's report and a written health history.
- Read an Individual Program Plan (IPP) and identify specific DSP responsibilities for helping to maintain the best possible health.
- Identify three ways germs spread infection.
- Identify appropriate times to wash your hands.
- Describe the correct procedure for hand washing.
- Identify when to use disposable gloves.
- Demonstrate the correct procedure for gloving.
- Apply professional ethics to personal care.

KEY WORDS

Disinfect: To kill or eliminate most germs with a chemical solution.

Germs: Microorganisms (bacteria, viruses, fungi) that need warmth, moisture, darkness, and oxygen to grow and live. Some germs are harmful and cause illness or infection, while others are helpful to digestion of food and the elimination of bodily waste.

Health History: A document that has both medical history and current information about an individual's unique health care needs.

Infection: Invasion and multiplication of germs in the body that cause illness or injury if not treated.

Personal Care/Personal Hygiene: Activities of caring for one's own daily needs to maintain health and good grooming.

Personal Protective Equipment: Protective gown, face mask, eye shield, or other equipment worn to protect the user from contact with body fluids and germs.

Standard Precautions: A set of infection control safeguards, including hand washing, using disposable gloves, and wearing of personal protective equipment, that protect both the individual being assisted and the DSP from the spread of germs.

Materials in Session 6 have been adapted with thanks from Expressions of Wellness, developed in 2000 by South Central Los Angeles Regional Center with funding from a Department of Developmental Services Wellness Initiative Grant.

The Best Possible Health

Health is the mind, body, and spirit working in harmony.

Each person deserves to have the best possible health considering his or her age and general condition. Many individuals with developmental disabilities have complex health needs that will last throughout their lives. In this session, you will learn many ways DSPs support individuals in maintaining the best possible health.

Habits that Maintain Good Health

Good health starts with healthy habits. DSPs can help individuals stay as healthy as possible by supporting them to make good health habits a part of their daily routines. Habits that maintain good health are the activities people do regularly or on a routine basis that contribute to good health. For example, taking the stairs instead of using the elevator or eating fruit instead of chips.

The following is a list of habits that contribute to good health. These are the same habits you should help the individuals you support learn and use.

Healthy Habits

- Eating the right amount of a variety of nutritious foods every day; for example, five servings of fruits and vegetables.
- Getting plenty of daily physical exercise (at least 30 minutes); for example, walking.
- Drinking 8 to 12 glasses of water every day.
- Brushing your teeth at least two times a day.
- Keep your body clean by taking regular showers and baths.
- Washing hands frequently.
- Getting regular medical and dental care according to each individual's IPP and doctors' recommendations.
- Seeking treatment early for medical and dental problems.
- Being free from physical, verbal, mental, and sexual abuse.
- Not smoking.
- Using relaxation techniques; for example, practicing yoga to relax.
- Practicing accident prevention at all times.
- Participating in regular recreational and leisure activities.

Health Information

Maintaining the best possible health is a continuing process. New health needs arise over time caused by many factors, including aging, onset of chronic disease, and other changes. In order to provide appropriate support and to protect their own health, DSPs should know basic health information about the individuals they support.

DSPs can find basic health information in each individual's health records. These records should include:

- Current physician's report
- Health history
- Individual Program Plan (IPP)

Each of these documents is a source of health information. It is essential that these documents be available in the home and that the information be kept up-to-date. Each DSP should know the plans for meeting the current medical needs of each individual in the home.

The DSPs will use this information when:

- Preparing to take an individual to a medical or dental appointment.
- Providing assistance with the self-administration of medication.
- Checking for information about allergies.
- Checking for information about past health conditions when a new sign or symptom is observed.
- Checking for information before providing personal care for the first time.
- Responding to emergency situations.

The Physician's Report

Individuals you support may be required to have an annual physical examination by a doctor even if they are not sick or having problems. Individuals may require more or less frequent exams depending on their health needs. The frequency should be described in each individual's IPP and/or recommended by the doctor. The doctor should record the results of the physical examination on the physician's report for Community Care Facilities provided by Community Care Licensing.

The physician's report includes the following information:

- Full diagnosis.
- Physical health status (blood pressure, temperature, pulse, weight, height).
- Mental health status.
- The results of tuberculosis testing.
- The presence or absence of allergies and communicable diseases.
- Whether the individual is ambulatory or non-ambulatory.
- An individual's capacity for self-care.
- Medications and conditions for use
  – over-the-counter
  – prescribed medications
- Lab tests and results
- Immunization status; for example, Hepatitis B.

The following is an example of a physician's report.

Physician's Report

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:		TELEPHONE:
THE GREEN HOME		405-677-9535
ADDRESS: NUMBER STREET: 1421 HIGH VIEW ST.	CITY: ROSELAND	
LICENSEE'S NAME: MARTHA GREEN	TELEPHONE: 405-677-9436	FACILITY LICENSE NUMBER: 0681402039

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:		TELEPHONE:
KWAN WANG		405-677-9535
ADDRESS: NUMBER STREET: 1421 HIGH VIEW ST.	CITY: ROSELAND	SOCIAL SECURITY NUMBER: 467-96-3573
NEXT OF KIN: JUDY WANG	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES: JUDY WANG	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS: Spastic Quadriplegia Cerebral Palsy

SECONDARY DIAGNOSIS: Severe M.R. / Seizure disorder

LENGTH OF TIME UNDER YOUR CARE: Approx. 4 yrs.

AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE?
45	5'	F	122	☐ YES ☒ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☒ INACTIVE ☐ NONE

DATE OF LAST TB TEST: 5/14/03

TYPE OF TB TEST USED: ppd

TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:		TREATMENT/MEDICATION:	
A) ☐ YES ☒ NO If YES, list below:		B) ☐ YES ☐ NO If YES, list below:	
ALLERGIES		TREATMENT/MEDICATION:	
C) ☒ YES ☐ NO If YES, list below:		D) ☐ YES ☒ NO If YES, list below:	
tomato products			

Ambulatory status of client/resident: ☐ Ambulatory ☒ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

(OVER)

Physician's Report

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☒ FAIR ☐ POOR

		YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1.	Auditory Impairment	✓			moderate left hearing loss
2.	Visual Impairment		✓		
3.	Wears Dentures		✓		
4.	Special Diet	✓			low salt/no tomato/high fiber
5.	Substance Abuse Problem		✓		
6.	Bowel Impairment	✓			chronic constipation
7.	Bladder Impairment		✓		
8.	Motor Impairment	✓			
9.	Requires Continuous Bed Care		✓		

II. MENTAL HEALTH STATUS: ☐ GOOD ☒ FAIR ☐ POOR

		NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1.	Confused	✓			
2.	Able To Follow Instructions	✓			
3.	Depressed	✓			
4.	Able to Communicate		✓		difficult to understand

III. CAPACITY FOR SELF CARE: ☐ YES ☒ NO

		YES (Check One)	NO (Check One)	COMMENTS:
1.	Able to care For All Personal Needs		✓	
2.	Can Administer and Store Own Medications		✓	
3.	Needs Constant Medical Supervision		✓	
4.	Currently Taking Prescribed Medications	✓		
5.	Bathes Self		✓	
6.	Dresses Self		✓	
7.	Feeds Self		✓	with specialized spoon and assistance.
8.	Cares For His/Her Own Toilet Needs		✓	
9.	Able to Leave Facility Unassisted		✓	
10.	Able to Ambulate Without Assistance		✓	
11.	Able to manage own cash resources		✓	

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	milk of magnesia 30cc on 3rd day w/ no bowel movement
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)* Pf Sunguard	in sun > 15 min.
Flourigard 15 cc	after toothbrushing AM/PM

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. Tegretol 200 mg. QID
2. OScal 1500 mg.
3.
4.
5.
6.
7.
8.
9.

PHYSICIAN'S NAME AND ADDRESS: Dr. Ubewell | TELEPHONE: 391-8511 | DATE: 5/15/03

PHYSICIAN'S SIGNATURE: D. Ubewell

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME: KWAN WANG

TO (NAME AND ADDRESS OF LICENSING AGENCY): THE GREEN HOME

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE: Kway Wang | ADDRESS: 76711 S. SAN PEDRO ST. ROSELAND, CA. 90375 | DATE: 4/29/03

97 35381

ACTIVITY

Finding Information in the Physician's Report

Directions: Look at the physician's report for Kwan and answer the following questions:

1. Does Kwan have any allergies? If yes, what are they?

2. What medications is Kwan taking?

3. Can Kwan feed herself?

4. Does Kwan wear dentures?

5. Is Kwan on a special diet?

6. What is Kwan's doctor's name?

Health History

What's in a Health History

A **health history** is often a combination of documents that provides information about the individual's:

- Diagnosis.
- Past and present illness(es).
- Family history of health care needs and illness.
- Current medications.
- Medication history.
- Current doctor(s) and dentist.
- List of known allergies.
- Immunization records.
- Emergency contact information.
- Regional center service coordinator.
- Previous surgeries.
- Previous hospitalizations.

Health History

NAME: Kwan Louise Wang **GENDER:** F **DATE OF BIRTH:** 4/18/58
CURRENT ADDRESS: 1421 High View Street, Roseland, CA 90375
PHONE: (405)677-9535
PRIMARY LANGUAGE: English
RESIDENCE TYPE: Community Care Facility, Service Level 4
ADMINISTRATOR: Martha Green **PHONE:** (405)677-9436
SERVICE COORDINATOR: Betsy Helpful **PHONE:** (405)546-9203

FAMILY INFORMATION

Judy Wang (Mother and Conservator) 76711 S. San Pedro St, Roseland, CA 90375
Home Phone (405)391-2537; Cell (405)636-2452
John Wang (Brother) 525 Avenida Esplendida, Ripart, CA 90275;
Home Phone (310)372-3610

HEALTH INSURANCE

Medi-Cal: (467)963-5738; Medicare: (467)963-5738

INFORMATION SOURCES

Sonoma Developmental Center and Everyone's Regional Center (ERC) placement packets; Hope Medical Center records; consumer record; verbal history from mother, Judy Wang.

RESIDENTIAL HISTORY

Home with parents Judy and Keith Wang	7/23/58 – 6/02/65
Sonoma Developmental Center	6/02/65 – 9/23/95
Appleby home (Ray Appleby, (402)797-7689)	9/23/95 – 1/06/03
Green home	1/06/03 – present

Primary Care Physician
Dr. Ubeewell, 7922 Spirit Street, Pleasantville, CA 90375 Phone: (405)391-8511

Neurologist
Dr. Nicely, 12 Fair Oaks Drive, Suite 3, Roseland, CA 90375 Phone: (405)333-7272

Gynecologist
Dr. Young, 12 Fair Oaks Drive, Suite 14, Roseland, CA 90375 Phone: (405)333-6789

Dentist
Dr. Y Nocaries, 12 Whitten Way, Pleasantville, CA 90375 Phone: (405)696-3372

Audiologist
Dr. Hearless, 1434 Hayes Way, Suite 200, Pleasantville, CA 90375
Phone: (405)333- 4536

Health History

DIAGNOSIS

Spastic Quadriplegia Cerebral Palsy, Severe Mental Retardation, Mixed Seizure Disorder, Right hip fracture with pinning (1998), Moderate hearing loss left ear (2002), Hypertension (2003)

HEIGHT: *5 feet* **WEIGHT:** *120 pounds*

ALLERGIES: *Tomatoes and tomato products*

HOSPITALIZATIONS

None in past year. See medical history for prior hospitalizations.

FAMILY MEDICAL HISTORY

Kwan's mother was diagnosed with breast cancer when she was 40 and had a mastectomy. Her father had asthma. He died of a stroke in 1994 at the age of 70. There is no other significant family medical history. Grandparents on both sides of the family lived into their early 80s and had generally good health.

MEDICAL HISTORY

Kwan was born at 32 weeks gestation at University Hospital after a 10-hour labor. Birth weight was 2 lbs, 10 ounces. Kwan was blue at birth and was rushed to neonatal intensive care. She remained there for three months being treated for sepsis and recurrent seizures. She was reported to be a beautiful but very frail and fussy infant. The pediatrician diagnosed cerebral palsy at nine months of age. Developmental milestones were all severely delayed. Kwan learned to sit up at age 3 and to crawl at 4 years. Speech was slow in coming. She experienced *grand mal* seizures frequently before age 4. Kwan attended special preschool but was often absent "due to colds and stomach problems." She had a tonsillectomy at age 4, and her health improved. Kwan never learned to walk and is wheelchair dependent. At age 7, Kwan's care needs became too much for her parents, and she was admitted to Sonoma Developmental Center where she remained until 1995. Her parents visited often over the years and took her on frequent home visits until Kwan's father died. Apart from occasional colds, chicken pox when she was 11, and chronic constipation over the years, she has enjoyed good health. She has been on a high fiber diet for years. She does not like tomatoes, and her mother says that they give her hives. Kwan's seizures were brought under better control when she was started on Tegretol in 1980. She moved from the developmental center to the Appleby home in 1995. Kwan had a right hip fracture with pinning in 1998. It healed well after it was pinned, but she is no longer able stand for pivot transfers. Just last year she moved to the Green home.

Health History

CURRENT MEDICAL HISTORY

In January of 2003, Kwan was diagnosed with high blood pressure. Medication has brought her blood pressure down to 132/86. The doctor ordered a therapeutic diet with no coffee or added salt. Kwan continues on her high fiber diet. She is allergic to tomatoes and tomato products. Although she is on stool softeners and laxatives, she continues to experience chronic constipation. Kwan's gums bleed easily as a result of gingivitis. Seizure frequency is reduced to about two to three *grand mal* seizures per year. Seizures last 1–2 minutes. Seizures sometimes are noted to be in association with episodes of severe constipation. An audiogram done in 2002 revealed a moderate left hearing loss. No hearing aid was recommended. Kwan has very fair skin and sunburns easily.

IMMUNIZATION HISTORY

Records show that Kwan had all her childhood immunizations and booster shots. She has not had the Hepatitis B series. Flu shot and pneumovax were given September, 2003.

MEDICATION HISTORY

Kwan took Phenobarbital/Dilantin for seizures from 1958 to 1970, when she was changed to Tegretol. She has taken Milk of Magnesia and various stool softeners for constipation since the late 1960s. When she turned 40, she began taking calcuim supplements. More recently (January 2003), she began taking Lotensin for hypertension. She also uses a Flourigard mouthwash to promote dental health and PF 35 sunguard and lipbalm to protect from sunburn.

CURRENT MEDICATIONS

- Tegretol 200 mg QID (four times a day, 7:00 a.m, 12:00 p.m., 5:00 p.m., 10:00 p.m.) with food for seizures.
- Colace 250 mg q AM (every morning) with a large glass of water for constipation.
- Milk of Magnesia 30 cc q 3rd day (every third day) with no bowel movement.
- OsCAL 1500 mg qd (every day) for prevention of osteoporosis.
- Lotensin 20 mg q AM (every morning) for hypertension.
- Fluorigard 15cc mouthwash after toothbrushing AM and PM for oral health.
- PF 35 sunguard and lip balm to protect from sunburn to be applied if Kwan is to be in the sun for more than 15 minutes.

Individual Program Plan (IPP)

Promoting and maintaining the best possible health depends upon the effective teamwork of the people involved in the individual's health care and health care planning and evaluation. A current health history and physician's report are used by the planning team to address health care needs when developing the IPP. The IPP provides information and direction for the individual's life. The IPP includes:

- Goals, objectives, and plans for health care needs.
- Specific responsibilities of the DSP and others.
- A way to evaluate the success of the plan in supporting the individual to achieve or maintain the "best possible health."

The following example IPP is for Kwan. This is the third piece of information from Kwan's health records which contains information about Kwan's health status and needs. It is important to look at all three reports when trying to understand all of Kwan's health needs, as each contains some different information. Look over Kwan's IPP to see what additional health information it contains.

Everyone's Regional Center (ERC)

Individual Program Plan (IPP)

Date of IPP Meeting: **4/1/04**

IDENTIFYING INFORMATION

Kwan Louise Wang (Name) F (Gender) 4/18/58 (Date of Birth)

1421 High View Street, Roseland, CA 90375 (Current Address) (405)677-9535 (Phone)

English (Primary Language) Community Care Facility, Service Level 4 (Residence Type)

Betsy Helpful (Service Coordinator) (405)546-9203 (Phone)

IPP MEETING PARTICIPANTS

Kwan Wang, Phone (405)677-9535

Judy Wang, mother and conservator, Home Phone (405)391-2537; Cell (405)636-2452

John Wang, brother, Home phone (310)372-3610

Martha Green, administrator of the Green home, Phone (405)677-9436

Mimi Rosales, direct support staff at the home, Phone (405)677-9535

Armand Garcia, Hillside Day Program counselor, Phone (405)638-4423

Betsy Helpful, ERC service coordinator, Phone (405)546-9203

FAMILY INFORMATION

Family Members

Judy Wang (Mother and Conservator) 76711 S. San Pedro Street, Roseland, CA 90375
Home Phone (405)391-2537; Cell (405)636-2452

John Wang (Brother) 525 Avenida Esplendida, Ripart, CA 90275
Home Phone (310)372-3610

Consumer/Family Concerns and Priorities

Kwan has a boyfriend, Robert, with whom she enjoys spending time. She would like support to be able to spend good, quality time with Robert. Kwan enjoys animals and has a pet bird. Someday, she would like to have more than one bird. In the meantime, Kwan would like to find more ways to be around animals, especially birds. She would also like a job since she wants to save money for her dream trip to Disneyland and to buy more clothes and CDs. Kwan also enjoys spending time with her mother and brother. She and her mother get together once a week for shopping and other activities. She doesn't see her brother as often, since he lives 50 miles away.

Individual Program Plan (IPP)

Kwan's mom wants Kwan to be happy in her new home. She is concerned that Kwan's fairly complicated medical needs are taken care of properly. She wants to continue to take a very active part in Kwan's life. She loves her daughter very much and wants to do what is best for her. Kwan's brother is concerned that Kwan's wheelchair needs to be replaced and wants to see Kwan get a new one as soon as possible. He also wonders if there isn't something that could help Kwan communicate more effectively, as it is very hard to understand her.

MEDICAL INFORMATION

Health Insurance: Medi-Cal (467)963-5738; Medicare (467)963-5738
(Father deceased)

Medications

- Tegretol 200 mg QID (four times a day, 7:00 a.m., 12:00 p.m., 5:00 p.m., 10:00 p.m.) with food for seizures.
- Colace 250 mg q AM (every morning) with a large glass of water for constipation.
- Milk of Magnesia 30 cc q 3rd day (every third day) with no bowel movement.
- OsCAL 1500 mg qd (every day) for prevention of osteoporosis.
- Lotensin 20 mg q AM, (every morning) for hypertension.
- Fluorigard 15cc mouthwash after toothbrushing AM and PM for oral health.
- PF 35 sunguard and lip balm to protect from sunburn to be applied if Kwan is to be in the sun for more than 15 minutes.

Health Providers

Primary Care Physician

Dr. Ubeewell, 7922 Spirit Street, Pleasantville, CA 90375 Phone: (405)391-8511

Neurologist

Dr. Nicely, 12 Fair Oaks Drive, Suite 3, Roseland, CA 90375 Phone: (405)333-7272

Gynecologist

Dr. Young, 12 Fair Oaks Drive, Suite 14, Roseland, CA 90375 Phone: (405)333-6789

Dentist

Dr. Y Nocaries, 12 Whitten Way, Pleasantville, CA 90375 Phone: (405)696-3372

Audiologist

Dr. Hearless, 1434 Hayes Way, Suite 200, Pleasantville, CA 90375
Phone: (405)333- 4536

Health Status

Height: 5 feet Weight: 120 pounds

Individual Program Plan (IPP)

Eligible Diagnosis: Spastic Quadriplegia Cerebral Palsy, Severe Mental Retardation. Mixed Seizure Disorder

Chronic medical conditions/special health issues: Kwan had a right hip fracture with pinning in 1998. She currently has a seizure disorder, hypertension (diagnosed in 2003), chronic constipation, and moderate hearing loss in the left ear (diagnosed in 2002). She has doctor's orders for a therapeutic diet (high fiber for constipation and no coffee or added salt for hypertension). In addition, she cannot eat tomatoes or tomato products.

Allergies: Kwan is allergic to tomatoes and tomato products. They give her hives. She is also sensitive to the sun and sunburns easily.

Equipment: Wheelchair, shower chair, adaptive spoon.

Hospitalizations: No hospitalizations in the past year.

Mental Health Issues: N/A

Immunizations: Kwan had a flu shot and pneumovax in September 2003.

NATURAL SUPPORTS

Kwan's mother and brother are both very close to Kwan and want to do as much to support her as they are able. Her mother visits Kwan once a week. Every fourth week she takes her shopping at the local mall. She goes with Kwan as often as she can to doctor visits. Kwan spends Thanksgiving and Christmas holidays with her mother and family. Kwan's boyfriend, Robert, is also an important source of support and fun.

WHAT PEOPLE NEED TO KNOW ABOUT KWAN

Kwan is a friendly and happy person who gets along well with others. She has a good sense of humor and likes to be with people and do fun things. Kwan enjoys her close relationship with her mother and brother. Kwan likes birds, especially her yellow parakeet Pete. She also loves having her nails polished and going shopping with her mom. Kwan likes watching TV, especially the Disney Channel. Kwan is able to express some of her needs verbally; however, when she is very excited, her speech is very difficult to understand. She hears best with her right ear. Kwan uses a wheelchair and needs assistance with most things. Kwan has very fair skin and is sensitive to sun.

HOPES AND DREAMS

Kwan enjoys spending time with Robert and would like more opportunities to be with him. Kwan loves her bird. She would like to someday work in a pet shop or someplace where there are lots of birds. She likes the water and would like to learn to swim. The thing that would make her happiest in the world would be to go to Disneyland with Robert.

Individual Program Plan (IPP)

CONSUMER/FAMILY SATISFACTION WITH SERVICES

Kwan likes her new home. The staff are nice, and she likes spending time with them, but she would like to have more friends and to spend more time with Robert. Kwan's mother, who is also her conservator, is happy with Kwan's new home as well.

FINANCIAL SITUATION

Benefits: Kwan receives SSI in the amount of $670 a month with an additional $90.00 for personal and incidentals (P&I). In addition, Kwan receives SSA in the amount of $270 a month. Her mother is her representative payee. She also maintains a bank account for Kwan. Kwan uses her P&I to purchase personal items, clothes and pet supplies for Pete and for weekly activities as needed.

LEGAL STATUS

Kwan's mother is her limited conservator and, as such, is authorized to sign for Kwan's medical care, handle her finances, and make decisions about where she lives.

INDIVIDUAL PROGRAM PLAN AREAS

HOME

Current Status: On January 6th this year (2004), Kwan moved to her new home, a level 4, owner-operated CCF. Martha Green is the owner and administrator. Kwan had to move because her previous service provider became seriously ill. Kwan likes her new home and particularly likes Mimi Rosales, one of the staff. It also helped that her previous roommate moved with her. There is one staff for every three individuals in the home at all times. In the morning and evening there is one additional staff. Kwan's mom was worried about the move, but is now satisfied that the new home is working for Kwan. Being able to keep her bird was one of the reasons she and her mom chose the Green home.

Goal

Kwan wants to live in a safe, comfortable, home that meets her needs and supports her choices and preferences.

Objective 1

1. The Green home will continue to provide Kwan with a safe and supportive living environment through 4/30/05.

Plans

1. Green home staff will provide services and supports for Kwan as described in Kwan's IPP and with consideration for Kwan's unique needs and preferences.
2. Martha Green, Administrator, will prepare a quarterly summary of activities and outcomes related to implementation of individual IPP objectives for which the facility is responsible.

3. ERC will continue to provide monthly payment at the Level 4 rate (minus the SSI and SSA amount) to the Green home for Kwan. Kwan's ERC service coordinator (SC) will visit Kwan once every three months or more frequently as needed to monitor the implementation of Kwan's IPP and Kwan and her mother's continued satisfaction with the services.
4. As representative payee, Kwan's mom will continue to provide monthly payment for Kwan to the Green home for the total amount of the SSI and SSA payments.

Objective 2

Kwan's staff will receive initial training prior to working with Kwan and ongoing yearly training in First Aid, CPR, and proper transfer and lifting procedures for Kwan.

Plans

1. Martha will contact the Red Cross and schedule staff training.
2. Staff will provide Martha with a certificate of completion of training to be maintained in their personnel file.

PERSONAL CARE

Current status

Kwan likes to wear nice clothes, make-up, and have her nails polished. Kwan uses an adaptive spoon to eat, but otherwise needs to be assisted with all her needs. She enjoys long showers. Kwan is unable to stand and pivot to transfer from her wheelchair. Kwan's wheelchair needs replacement. It is 8 years old, and the upholstery is ragged and the frame wobbly. The brakes were recently repaired.

Goal

Kwan wants to look nice, be comfortable and be treated respectfully by staff whent they are assisting her. She wants to do things as independently as possible. She needs a new wheelchair.

Objective 1

Kwan will maintain good oral health, healthy skin, and will be assisted to dress and groom herself appropriately for the occasion and the season through 4/30/05.

Plans

1. Home staff will provide complete assistance to Kwan with bathing, dental care, dressing, toileting, grooming (including makeup) with concern for her privacy and dignity and provide Kwan with opportunities for choice throughout her daily routine. Staff will schedule extra time for Kwan's shower.

2. Home staff will assist Kwan to floss Kwan's teeth once a day and brush with an electric toothbrush twice a day. They will assist Kwan in using Flourigard as prescribed after each brushing.
3. Home and day program staff will assist Kwan to shift position in her wheelchair once every 2 hours. Home staff will assist Kwan to transfer from her wheelchair to a beanbag for an hour each night at home while she is watching her favorite TV program or listening to music.
4. Both home and day program staff will assist Kwan to apply sunscreen, lip balm, and a hat each time she is in the sun for any extended length of time (more than 15 minutes).

Objective 2

Kwan will be supported to eat as independently as possible through 4/30/05.

1. Home and day program staff will ensure that Kwan has her adaptive spoon when eating and will provide partial assistance and verbal prompts to guide Kwan to eat as independently as possible.

Objective 3

Kwan will get a new wheelchair by 10/1/04.

Plans

1. Kwan's SC will arrange for Jacquie Ohanesian, CRT, at First Care Equipment, (405)696-4651, to assess Kwan's wheelchair. ERC will fund the assessment.
2. Within two weeks of the completed assessment, the service coordinator will schedule a meeting with Kwan, her mom, and Martha Green to discuss the results of the evaluation and write an IPP addendum for the purchase of the wheelchair. If Medi-Cal will not approve the purchase of the recommended wheelchair, ERC will purchase.

COMMUNICATION

Current status

Kwan is a friendly and happy person. She has a good sense of humor and likes to be with people. Kwan is able to express some of her needs verbally; however, at times when she is very excited, her speech is very difficult to understand. An audiogram done in 2002 revealed a moderate left ear hearing loss. No hearing aid was recommended. Kwan hears best when people direct their speech directly at her or towards her left ear. Her brother is concerned that there may be some way to assist her to communicate more effectively.

Goal

Kwan will be supported to communicate as effectively as possible.

Objective 1

Kwan will be evaluated for use of augmentative communication strategies and devices by 10/1/04.

1. Kwan's SC will arrange for Liz Speakeasy, Speech Therapist, to assess Kwan for use of augmentative communication. The speech therapist will assess Kwan in different environments and situations. Medi-Cal will fund the assessment.
2. Within two weeks of the completed assessment, the service coordinator will schedule a meeting with Kwan, her mom, and Martha Green to discuss the results of the evaluation and write an IPP addendum for the purchase of any necessary augmentative communication device.
3. Home staff will follow any plans developed by by the Speech Therapist.

FAMILY, FRIENDS and FUN

Current Status

Kwan lives with three other women close to her age. Kwan likes visiting with her mother and brother, especially during the holidays. Her mother and brother visit her often. Kwan has told Mimi Rosales that she wants to spend more time with her new friend, Robert. Her life's dream would be to go to Disneyland with Robert. She also loves having her nails polished and going shopping with her mom. Kwan especially enjoys shopping for clothes, make up, and jewelry. Kwan likes watching TV, especially the Disney Channel. In February, Kwan attended a Valentine's Day Party. She is very proud of the picture taken of her at the party that shows how pretty she looked in her red dress. Her mom framed it.

Goals

Kwan wants to see family and Robert on a regular basis, make more friends, and participate in more community activities.

Objective 1

Martha and her staff will provide support for Kwan to participate in fun activities of her choice in her local community at least once a week.

Plans

1. At Kwan's request, home staff will support her to arrange and coordinate visits with Robert.
2. As pre-arranged with Kwan's mom, home staff will arrange for Dial-A-Ride to take Kwan to and from the mall to meet her mother for shopping.
3. Staff will assist Kwan in exploring additional community activities that interest her, for example, Audobon Bird Society activities.

Objective 2

By October 1, 2004, Kwan's plan for going to Disneyland will be developed.

Plans

1. Kwan's mom will develop a budget and help Kwan save money for a Disney trip.
2. Mimi Rosales volunteered to help Kwan arrange the trip, perhaps to coincide with a National Self-Advocacy Conference being held in Anaheim in September 2005.

HEALTH

Current Status

In late January of this year (2003), Kwan was diagnosed with high blood pressure. Medication has brought her blood pressure down to 132/86. The doctor ordered a diet with no coffee or added salt. Kwan continues on her high fiber diet. She is allergic to tomatoes and tomato products. Although she is on stool softeners and laxatives she continues to experience chronic constipation. Kwan's gums bleed easily as a result of the gingivitis. Seizure frequency is reduced to about two to three *grand mal* seizures per year. Seizures last 1–2 minutes. Seizures sometimes are noted to be in association with episodes of severe constipation.

Kwan's last visit to her primary care physician, Dr. Ubeewell, was 5/14/03. Her blood pressure was within normal range. Kwan is to return every three months or more frequently as needed. Kwan's last visit to her neurologist, Dr. Nicely, was 7/12/02. Her serum blood level for Tegretol and TSH was normal. She is to return yearly or more frequently as needed. Lab work needs to be done prior to visit (call doctor for order). Kwan last saw her gynecologist, Dr. Young, on 1/30/03. Dr. Young works with the Adult Special Disabilities Clinic at University Hospital, and Kwan feels very comfortable. She has an examining table which makes transfer from her wheelchair easy. She had a breast exam and Pap smear on the same date and a mammogram on 3/22/03. Findings were normal for both. Kwan is to return for a yearly breast exam, pap smear, and mammogram (Bay Area Breast Center). Kwan went to her dentist, Dr. Nocaries, on 2/28/03. She had two small cavities that were filled, and her teeth cleaned. She is to return two times a year. She saw Dr. Hearless, her audiologist, on 2/15/03. Dr. Hearless diagnosed moderate hearing loss in her left ear. She is to return once a year for follow-up audiogram.

Goal

Kwan will be supported to have the best possible health.

Individual Program Plan (IPP)

Objective 1

Kwan will receive ongoing medical and dental care and age- and gender-appropriate health screenings through 4/30/05.

Plans

1. Martha will make all necessary medical and dental care appointments. Martha will make appointments on the following schedule:
   Primary Care Physician: Dr. Ubeewell, last visit 5/14/04; return quarterly or more frequently as needed.
   Neurologist: Dr. Nicely, last visit 7/12/02; return yearly or more frequently as needed, and call doctor for lab order prior to yearly visit.
   Gynecologist: Dr. Young, last visit 1/30/03; last Pap smear 1/30/03; last mammogram 3/22/03; return for yearly Pap smear and mammogram.
   Dentist: Dr. Nocaries, last visit 2/28/03; return two times a year.
   Audiologist: Dr. Hearless, last visit 2/15/03; return once a year for follow-up audiogram.
2. Kwan's mother wants to accompany her to her yearly neurologist appointment, her twice-yearly dental appointments, and her yearly audiogram appointment.
3. Martha or a home staff member will accompany Kwan to all medical and dental appointments, provide necessary information, document all visits and the outcome in Kwan's notes, and follow doctor's recommendations. Martha will notify Kwan's mother of any scheduled appointments, as well as any changes in Kwan's health, such as illness, injury, and any hospitalization or ER visit.
4. Martha and both home and day program staff will keep and share a record of Kwan's seizures. If the frequency or duration of seizures increases, Martha will call Dr. Nicely.
5. Martha will ensure that home staff are trained to safely assist Kwan with medications and that staff document each dose.
6. Martha will provide the day program with a pharmacy-prepared and labeled bottle of Tegretol for Kwan's midday dose. Armand Garcia will ensure that day program staff who assist Kwan are trained to safely assist her and that they document each dose.
7. On at least a quarterly basis, Kwan's ERC SC will review Kwan's ongoing notes, seizure log, bowel log, medication, and other health records for any changes or special incidents to ensure appropriate response.

Objective 2

Staff will follow menu plan and therapeutic diet developed by Green home dietician through 4/30/05.

Plans

1. Dietician to review menus with Kwan and her mother to incorporate Kwan's food preferences.
2. Martha will coordinate menus with Kwan's day program.
2. To help prevent constipation and maintain good health, staff at Kwan's home and day program will offer Kwan water throughout the day.
3. Home and day program staff will keep and share a daily record of Kwan's bowel movements. On every third day without a bowel movement, home staff will assist her to take the prescribed dose of Milk of Magnesia and document in Kwan's medication log. If she has no bowel movement on the next day, home staff will call Dr. Ubeewell.

EDUCATION/WORK/DAY ACTIVITY

Current Status

Since her move to the Green home, Kwan has attended Hillside Day Program, 73468 Southside Lane, Roseland CA 90375, telephone (405)696-1173. The program has a one-to-three staff ratio to support individuals who use wheelchairs, like Kwan. Kwan's activities include music appreciation, artwork, and a class on current events. Kwan has a longer lunchtime so that she doesn't have to hurry. She also gets additional assistance to help her while she is eating. She has made several friends at Hillside and has a special new boyfriend Robert. She enjoys the half-hour bus trip to the Center since Robert is on the bus, and they sit together. Kwan likes water and has expressed a desire to swim in a pool. Kwan likes birds and has expressed a desire to work in a pet shop someday where there are lots of birds.

Goal

Kwan wants to expand her daytime activities to include swimming and more community activities including someday working in a pet shop.

Objective 1

Kwan will be supported during the day to achieve her education/work and community activity goals through 4/30/05.

Plans

1. ERC will continue to fund Hillside Day Program for Kwan. Kwan's ERC SC will visit Kwan at the day program at least once every six months or more frequently as needed to review Kwan's IPP and Kwan and her mother's satisfaction with services.

2.. Dave Chauncey at New Horizon Bus Services, 5567 Studebaker Circle, Roseland, (405)333-2056, will provide transportation to and from the day program five days a week. Dave will ensure that all drivers are trained in First Aid and correct tie- down procedures for wheelchairs. ERC will fund the transportation service.

Objective 2

Given doctor's approval, Kwan will swim at least twice a week at a community pool through 4/30/05 or as long as Kwan continues to enjoy swimming.

Plans

1. Within the next month, Martha will make an appointment for Kwan with Dr. Ubeewell to discuss her desire to swim. Kwan's mom will accompany her.
2. Following instructions from Kwan's doctor, day program staff will make arrangements for and support Kwan to swim at least twice a week.

Objective 3

Given day program staff support, Kwan will participate in at least one community activity a week that is related to an area of her interest through 4/30/05.

Plans

1. Day program staff will help Kwan to find community groups with an interest in birds and support Kwan in becoming involved.
2. Day program staff will take Kwan on weekly visits to a local pet store, bird aviary, and other places where Kwan can share her interest in birds.
3. Martha will collaborate with Kwan's day program to ensure she is supported by home staff to swim and engage in more community activities.

I certify that I have participated in the development of the IPP and give permission for the plan to be carried out. I further understand that, if changes occur before the scheduled Annual Review of this plan, I may contact the Regional Center to discuss any needed modifications to the plan.

The Everyone's Regional Center Complaint and Appeal Process have been explained to me. I have been informed that I will receive a copy of this plan.".

"I approve the continuation of my current service coordinator".

Signature	Relationship	Date
Signature	Relationship	Date

ACTIVITY

Supporting the Best Possible Health

*Directions: Using Kwan's health records (the physician's report, health history, and IPP), list five of Kwan's health care needs. Then, pick **one** of the needs you listed and describe, according to the IPP, what the DSP must do to provide support.*

Health Care Needs

1. . . . . .

2. . . . . .

3. . . . . .

4. . . . . .

5. . . . . .

DSP Support Necessary: Using the IPP for Kwan, describe what the DSP must do to provide support in **one** of those health care need areas you described above.

Health Care Need # _____

Infection Control

Infection control is preventing the spread of **germs** that cause illness and infection. Infection control starts with understanding germs and how they are spread.

About Germs

Everyone comes in contact with millions of germs (microorganisms) each day. All germs need warmth, moisture, darkness and oxygen to live and grow. Many germs are harmless and are needed for our bodies to function in a healthy way. For example, certain kinds of germs or bacteria are needed for the digestion of food and for the elimination of waste products (feces and urine) from our bodies. Some germs are very harmful and cause infections, diseases, and illnesses by rapidly multiplying and overwhelming the body's natural defenses. An infection can be local in one spot, like an infected cut, or it can be systemic, throughout the whole body, like food poisoning or pneumonia.

Three Ways Germs Are Spread

Germs are spread in the environment three ways: direct contact, indirect contact, and droplet spread.

1. **Direct Contact** means that germs are spread from one infected person to another person.

   An example of direct contact is the person infected with a cold putting his hands to his mouth while coughing or sneezing and then touching or contacting another person before he has washed his hands. A similar situation happens when the person has an infected or open sore or wound or body fluids that are full of germs (feces, urine) or blood (HIV, AIDS, Hepatitis A, B, or C) or saliva that is contaminated, and the other person is contacted directly by the germs.

2. **Indirect Contact** means that germs are spread from one infected person to an object to another person.

   The germ from the person infected contaminates the object, and the person who touches the object is then contaminated. Indirect contact is a common way for germs to spread between people who live, work, and play together. The spread of germs through indirect contact can happen when eating contaminated food (E. coli, salmonella), handling soiled linens, soiled equipment, using soiled utensils and cups, and drinking or using contaminated water. Dysentery, a serious gastrointestinal infection, can be spread indirectly. The hepatitis B virus can live up to 10 days in dried blood and can also be spread indirectly.

3. **Droplet Spread** means that germs are spread through the air from one infected person to another person.

   The germs are airborne and are carried over short distances. When people talk, cough, or sneeze, they are spreading germs through the air. The germs of the common cold, flu, and even tuberculosis travel from one person to another by droplet spread.

ACTIVITY

How Germs Are Spread

Directions: Under each of the headings, list at least three ways that germs can be spread. For example, touching someone's contaminated sheets is an example of indirect contact.

Direct Contact	Indirect Contact	Droplet Spread

Infection Control (continued)

Controlling the Spread of Germs

Knowing how germs are spread is the first step in practicing infection control and preventing illness. Knowing how to control the spread of germs is the second step. DSPs can protect both themselves and the individuals with whom they work from germs or contamination by doing the following:

1. Know and practice standard precautions (defined in next section), especially hand washing and gloving.
2. Keep yourself, the individual, and the environment clean.
3. Be aware of the signs and symptoms of illness and infection, and accurately record and report them to the doctor.

Standard Precautions

Standard precautions, including hand washing and using disposable gloves and the wearing of personal protective equipment, protect both the individual and the DSP from the spread of germs and infection.

Standard precautions are a set of infection control safeguards. They are especially important to prevent the spread of blood-borne and other infectious diseases (AIDS, Hepatitis A, B, and C). The DSP should use these precautions when coming in contact with blood and all body fluids, secretions, and excretions (urine and feces), whether or not they contain visible blood; when touching mucous membranes such as the eyes or nose; and when dealing with skin breakdown such as a cut, abrasion, or wound. Body fluids include:

- Blood
- Blood products
- Secretions
- Semen
- Vaginal secretions
- Nasal secretions
- Sputum
- Saliva from dental procedures
- Excretions
- Urine
- Feces
- Vomit

Handwashing

Frequent, thorough, and vigorous hand washing will help in decreasing the spread of infection. **Germs are spread more frequently by hands and fingers than by any other means.**

When DSPs Should Wash Their Hands

DSPs should routinely wash their hands when they come to work and before leaving.

Hands should be washed at work at least before touching:

- Food.
- An individual's medicine.
- Kitchen utensils and equipment.
- Someone's skin that has cuts, sores, or wounds.
- Before putting on disposable gloves.

DSPs should always wash their hands at least after:

- Using the bathroom.
- Sneezing, coughing, or blowing one's nose.
- Touching one's eyes, nose, mouth, or other body parts.
- Touching bodily fluids or excretions.
- Touching someone's soiled clothing or bed linens.

Standard Precautions (continued)

- Providing assistance with medications.
- Providing assistance with bathing or toileting.
- Removing and disposing of used disposable gloves.
- Touching anything else that could be contaminated with germs.
- Smoking.

Since hand washing can easily dry out a person's skin, remember to apply hand lotion or cream often throughout the day.

It is a best practice to keep natural nails short and avoid the use of artificial nails when providing personal care. Many hospitals have banned artificial nails and natural long nails for employees who provide personal care. Research has shown that healthcare workers who wear artificial nails are more likely to harbor germs than those who don't. DSPs with long nails are at risk of puncturing or tearing disposable gloves.

Gloving

Practicing standard precautions also includes the wearing of disposable (single-use) latex gloves whenever the DSP comes in contact with body fluid. (Non-latex gloves can be purchased for people who are allergic to latex.) Putting on disposable gloves and taking them off correctly is especially important in preventing the spread of germs and infection.

Gloves should be used only one time and changed after each use**.** New gloves should be put on each time a DSP works with a different individual. Used or contaminated gloves should be thrown away. Gloves become contaminated after each use and can spread germs between individuals if used more than once and if they are not properly disposed.

If bodily fluid or blood touches the skin, wash the area vigorously and thoroughly with soap and warm water. If the gloves tear or break, take them off and vigorously and thoroughly wash your hands. Put on a new pair of gloves and continue assisting the individual.

DSPs should follow the method for putting on disposable gloves as demonstrated in the gloving technique diagram in Appendix 6-B and in the video.

DSPs should use gloves at least while doing any of the following activities:

- Cleaning rectal or genital area.
- Giving mouth care.
- Shaving with a blade razor.
- Cleaning bathrooms.
- Cleaning up urine, feces, vomit, or blood.
- Providing or assisting with menstrual care.
- Providing wound care.
- Handling soiled linen or clothing.
- Giving care when the DSP has open cuts or oozing sores on his or her hands.
- Disposing of waste in leak proof, airtight containers.

DSPs should wash their hands before putting on disposable gloves and immediately after removing gloves.

Other Protective Equipment

Depending on your job, you may be expected to wear other **personal protective equipment** (PPE), such as a facemask or eye shields. If a DSP needs these, it is important that a health care professional teaches the person the correct use and disposal of these items.

Cleaning and Disinfecting

The second way for DSPs to prevent the spread of germs is through cleaning and disinfecting the environment. DSPs should be careful not to transfer infection to others and equally important, the DSP should be careful not to be infected by others. The DSP can help do this by being clean themselves, keeping the home clean and germ free, and assisting the individuals in the home to maintain good personal hygiene.

Routine, daily cleaning of household surfaces and other items with soap and water is the most effective method for removing germs. Sometimes, an additional cleaning is needed to be germ free. This extra step is called disinfection.

Disinfection is the process of killing germs after cleaning with soap and water and rinsing with clear water. Disinfecting usually requires soaking or drenching the surface or item for several minutes with a special cleaning solution. This soaking allows the cleaning solution to kill the remaining germs. One of the most common cleaning solutions is household bleach and water. Two recipes for a disinfectant cleaning solution are in Appendix 6-C. The recipes are easy to mix, safe if handled properly (as a toxic substance), and kill most infectious agents. Remember, this solution will discolor fabric and carpeting. The solutions lose effect very quickly and must be made fresh daily.

Household Hints for Reducing the Spread of Infection

- Clean most surfaces with soap and water to remove germs.
- Always clean up spills from the less soiled to the most soiled to limit the spread of germs.
- Handle soiled laundry as little as possible.
- Wash soiled clothing and linens separately from other clothes.
- Use paper towels throughout the house.
- Make sure everyone follows good hand-washing practices (for example, before touching food, after using the bathroom).
- Keep clean hands away from the face and other areas of the body.
- Make sure individuals use their own toiletries and equipment (for example, combs, brushes, razors, etc.)

You have learned how to prevent the spread of germs by practicing standard precautions and by cleaning and disinfecting the environment. Yet another way DSPs can prevent the spread of germs is to observe the signs and symptoms of illness and injury in an individual and record and report them.

Providing Personal Care

As a DSP, you may have many different responsibilities including assisting the individuals in the home with **personal care**, such as bathing, oral hygiene, shaving, dressing, toileting, and menstrual care. These activities are very important and unique for each individual. Remember good hygiene helps prevent the spread of germs, the individual to maintain the best possible health and feel good about themselves.

The DSP's toolkit includes a set of professional ethics that guides the DSP in everything he or she does. When assisting individuals with personal care, the DSP should be especially mindful of professional ethics. These ethics or principles become routine as they are practiced and applied each day. As a DSP, you will want to apply your professional ethics every time you assist and support an individual with personal care skills.

- **Respect:** As a DSP, I will respect the individuals I support and help others recognize their value. Personal care should be provided with dignity and respect for the individual.

- **Promoting Physical and Emotional Well-Being:** As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of individuals receiving support while being attentive and energetic in reducing their risk of harm. Personal care should be provided safely and in a way that promotes the physical and emotional well-being of the individual.

- **Confidentiality:** As a DSP, I will protect and respect the confidentiality and privacy of the individuals I support. An individual has the legal right to have his or her support needs kept confidential and to privacy for personal care.

- **Honesty and Responsibility:** As a DSP, I will support the mission of my profession to assist individuals to live the kind of life they choose. I will be a partner to the individuals I support. Individuals should be supported in doing as much for themselves as possible.

- **Self-Determination:** As a DSP, I will assist the individuals I support to direct the course of their own lives. Individuals have the right to direct how personal care is provided.

Part of the job of a DSP is to support individuals so they can be more independent. Some individuals may be able to bathe, shave, dress, and otherwise take care of themselves with no support. Others may need assistance or support to complete their personal care activities. Depending on the abilities of each individual, the DSP will need to provide more or less support.

It is important to remember that having opportunities to make choices is a key to leading a healthy happy life. Just as individuals have the opportunity to make choices about what clothes to wear and what to eat, the need to have the choice as to how and when they complete their personal care activities. For example, one individual might like to bathe at night, while another likes to shower in the morning. The DSP needs to be aware of these individual preferences and support them.

Personal Care Guidelines

Hair Grooming

Having clean, well groomed hair is important to everyone, and is no less so for the individual you support. Individuals like different brands of shampoo or conditioner and may have a preferred style. Individuals may also change their minds about how they style their hair. All of these choices should be respected and supported.

Fingernail and Toenail Care

Cleaned and trimmed fingernails and toenails are important for overall health. Germs often collect underneath the nails. Frequent and thorough hand washing and foot care is a good way to prevent germ or fungus buildup. Nails that become too long and/or are rough and torn can scratch and cut an individual's skin and may result in a local infection.

Some individuals (those with diabetes) should have their nail care completed by a health care professional. Athlete's foot, a fungus that causes an inflammation, cracking, and peeling of the skin between the toes and can also infect the toenails is of particular concern, and must be treated as soon as it is noted by the DSP. Individuals often like to have nail color applied and may need assistance.

Shaving

Once again, shaving one's legs, underarms, or face is a very personal matter. Cultural differences may be a key to whether an individual shaves or does not shave. For example, in some cultures, women do not shave their legs or underarms. In some cultures, men do not shave their facial hair. It is important to assist and support the individual to shave safely and to avoid nicks and cuts that can lead to infection. Some individuals may learn to use an electric razor. Other individuals may be assisted and supported in using a blade razor.

Bathing and Perineal Care

Bathing means cleaning one's body from head to toe. Perineal care means the bathing of the genital and anal (rectum) area, or "private parts." Providing assistance and support for bathing can be a very sensitive personal care activity for an individual and a DSP. Routinely, this activity is completed by female DSPs for women and girls and by male DSPs for men and boys.

The DSP needs to know what bathing skills an individual has before beginning to provide assistance and support. It is important that the DSP provide whatever assistance and support is needed to ensure individuals are clean. Occasionally checking an individual's personal care skills and assisting when needed will help prevent body odor, discomfort, and infection. Step-by-step procedures and explanations for supporting individuals in personal care activities are included in Appendices 6-D – 6-G for this session. These procedures should be adapted to the specific needs and preferences of each individual the DSP supports.

> It is the job of the DSP to continue to teach, assist, and support each individual in learning good personal care habits. Each individual will have the opportunity to lead a fuller, happier, more enjoyable life as they become more independent with their own care needs. Remember, good personal hygiene is important to promoting good health.

Maintaining the Best Possible Health

1	A	B	C	D
2	A	B	C	D
3	A	B	C	D
4	A	B	C	D
5	A	B	C	D
6	A	B	C	D
7	A	B	C	D
8	A	B	C	D
9	A	B	C	D
10	A	B	C	D

1. **Keeping the teeth and body clean, getting plenty of physical exercise, and not smoking are examples of:**
   A) Accident prevention.
   B) Healthy habits.
   C) Physical abuse.
   D) How to avoid growing older.

2. **A person's "health history" is often or usually:**
   A) A collection of different documents about the person's health history and current health care needs.
   B) Kept under refrigeration to keep the information fresh.
   C) Shared with every visitor who comes to see the person.
   D) Another name for the "Physician's Report."

3. **The person's IPP (individual program plan) is a useful source of health information because:**
   A) It explains what the DSP's responsibilities are in helping the person have the best possible health.
   B) No other information on the person's health is kept at the facility.
   C) A person's IPP always contains the most up-to-date health information.
   D) The IPP by law includes a complete copy of the person's health history.

4. **Droplet spread of germs can occur when:**
   A) Butter or margarine is placed on untoasted bread.
   B) Handwashing is not done correctly.
   C) Food is dropped onto an unclean floor.
   D) A person coughs or sneezes near other people.

5. **Standard precautions for infection control include all of the following except:**
   A) Heating all food and drink to 212 degrees Fahrenheit.
   B) Handwashing.
   C) Use of disposable gloves.
   D) Avoiding direct contact with body fluids.

6. **Because frequent handwashing can easily dry out a person's skin:**
   A) It is recommended that DSPs wash only when entering and leaving the facility.
   B) Disposable gloves should be put on before washing the hands.
   C) DSPs should apply lotion or cream to their hands through the workday.
   D) DSPs always have irritated, dried-out, and cracked skin on their hands.

7. The DSP should use disposable gloves:
A) Until all germs have been removed from the facility.
B) When it is impossible to wash the hands instead.
C) For not more than one day before discarding them.
D) Only one time before discarding them.

8. After removing disposable gloves, the DSPs should always:
A) Wash the gloves.
B) Leave the facility for a rest break.
C) Wash their hands.
D) Place lotion or cream on their hands.

9. For adequate cleaning of most surfaces:
A) Soap and water is sufficient.
B) A facemask or eye shields must be worn.
C) A solution of bleach and water is usually required.
D) Sandpaper or steel brushes may be substituted for soap and water.

10. The personal care subject of shaving is a particularly sensitive one because:
A) Most people have sensitive underarms.
B) Cultural differences often play a role in determining preferences.
C) Certain persons may learn to use an electric razor.
D) Dull razor blades can make shaving uncomfortable.

Appendices

I Want To Know

I am entitled to good health care to increase my knowledge and become more aware.

To know my body and what to expect when something goes wrong and I do get sick.

I want to know about my eyes and ears and when to seek medical attention without any fears.

I want to know what makes my heart beat and how to take care of my gums and teeth.

I want to know what makes me breathe and what happens when I sneeze.

I want to know about my stomach and intestines of what I eat and of good nutrition.

I want to know what vaccinations I need to help and protect myself from a specific disease.

I want to know when to call my doctor and what to tell him or her without any proctor.

I want to know about the medicines prescribed or what they do to help me inside. I want to know about my glands and my nerves.

I want to stay healthy because it's what I deserve.

Irene Olsakowski

Appendix 6-B

GLOVING/SKILL CHECK #2

Directions: Partner with another member of the class. Each partner should have a Skill Check Worksheet. Using the worksheet, practice all the steps in this skill. Have your partner check off each step you correctly complete (Partner Check). When you are comfortable that you are able to correctly complete all the steps without using the worksheet, ask the teacher to complete the Teacher Check.

Reminders

Always wear disposable gloves when you:

- Assist another person with toothbrushing or flossing, bathing, shaving, menstrual care, and cleaning the rectal or genital area.
- Clean up toilets, urine, feces, or vomit.
- Perform first-aid.

Always use a new pair of gloves for each activity.

Always use a new pair of gloves for each individual.

Always wash your hands before and after using gloves.

Never wash gloves and use again.

Supplies

Gather all of the necessary supplies for skill check.. Supplies are needed for practice and skill check..

- Water, soap, and paper towels for hand washing.
- New disposable gloves (At least two pairs—one for practice and one for final skill check.).
- Waste container.
- Skill Check #2 Worksheet.

Competency: Each student is required to complete Skill Check Worksheet, Gloving, with no errors.

_____

TEACHER

_____

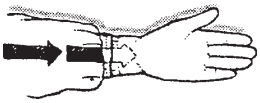
STUDENT

_____

DATE

Appendix 6-B (continued)

GLOVING

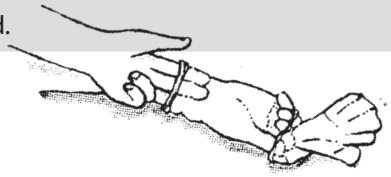


Please initial each step when completed correctly

Steps—Putting on Gloves	Partner Check: Attempt #1 Date	Partner Check: Attempt #2 Date	Partner Check: Attempt #3 Date	Teacher Check
1. Remove rings and watches.				
2. Wash your hands.				
3. Select a new pair of gloves of the appropriate size.				
4. Pull the gloves onto both hands.				
5. Smooth out folds to ensure a comfortable fit.				
6. Carefully look for tears, holes, or discolored spots and replace the glove(s) with new ones if necessary.				

Steps—Taking off Gloves

1. Touching only the outside of one glove, pull the first glove off by pulling down from the cuff.				
2. As the glove comes off your hand, turn the glove inside out.				
3. With the fingertips of your gloved hand, hold the glove you just removed.				



4. Put fingers of your bare hand inside the remaining glove, being careful not to touch any part of the outside of the glove.				
5. Pull the glove down, turning the glove inside out and over the first glove as you remove it.				
6. Drop both contaminated gloves into the proper garbage container.				
7. Wash your hands.				

Certification

This is to certify that

_____

(Name of student)

correctly completed all
of the steps for Gloving.

_____

Teacher Signature Date

*Comments*_____

_____

_____

_____

_____

Appendix 6-C: Two Recipes for Bleach and Water Cleaning Solution

Both disinfectant cleaning solutions are easy to mix, safe if handled properly, and kill most infectious germs. Never mix bleach with anything but fresh tap water. Mixing it with ammonia or other cleaning products may cause the formation of a toxic chlorine gas.

Remember bleach solutions:

- Loose their effectiveness quickly and need to be made daily.
- Must be stored properly in a sealed and labeled container in a locked storage area.
- Should be kept in a cool place out of direct sunlight.
- Will discolor fabrics and carpeting.
- Are harmful if swallowed or gets in the eyes or nose.

Bleach and Water Cleaning Solution for Bathrooms, Diapering, or Incontinent Brief Changing Areas and Floors

Ingredients

- 1/4 cup (2 ounces) bleach.
- 1 gallon tap water.

Procedure

- Add the household bleach (5.25% sodium hypochlorite) to the water.
- Carefully mix well.
- Store in closed, labeled container in cool, dark, locked storage area.
- Remake daily.

Bleach and Water Cleaning Solution for Cleaning Eating Utensils, Toys, Counter Tops, and Other Items That Are Mouthed or Come into Contact with Bodily Fluids

Ingredients

- 1 tablespoon bleach.
- 1 gallon cool tap water.

Procedure

- Add the household bleach (5.25% sodium hypochlorite) to the water.

Carefully mix well.

- Store in closed, labeled container in cool, dark, locked storage area.

Appendix 6-D: Hair Grooming

Attention

- Remember, hairstyle is an individual choice.
- Use only the individual's personal comb and brush.
- Clean comb and brush regularly.
- Combs with sharp teeth can injure sensitive scalps.
- Use comb and brush with a gentle touch.
- Encourage the individual to do as much as he or she can for him/herself.

Supplies

- Comb
- Brush
- Mirror
- Personal hair products

PROCEDURE

- Ask the individual if he or she has a preference for his or her hairstyle today.
- Teach and assist with drying wet hair with dryer and applying gels, hair spray, and other hair products as appropriate.
- If hair is long, divide into sections before combing or brushing.
- Teach and assist the individual to comb or brush hair from scalp to ends of hair. *Note: If the hair is tangled, use a wide-tooth comb.*

  Why? Pulling on tangled hair can cause damage to the hair. Gently combing or brushing from the scalp to the ends of the hair stimulates circulation.
- Encourage the individual to look in a mirror when finished styling.

  Why? Having hair clean and groomed looks great, increases self-esteem, and you can't have a "bad hair day"!

Appendix 6-E: Cleaning and Trimming Nails

Attention

- Special care should be practiced when assisting with nail care.
- Individuals with diabetes require professional assistance with nail care.
- Toenails and fingernails should be kept clean, neatly trimmed, and smooth to prevent injury to skin.
- Trimming the nail too short may cause ingrown nails that can be painful and cause infection.
- Encourage individuals to do as much as they can for themselves.

Supplies

- Personal nail clippers or nail scissors
- Personal cuticle or orange stick
- Bathtub or bowl
- Clean water
- Soap
- Personal towel
- Personal emery board or nail file

PROCEDURE

- Teach and assist the individual how to soak his or her hands or feet in warm water for at least 5 minutes and then wash hands or feet with soap.

  Why? Soaking will soften the nails and make them easier to trim.
- Teach and assist how to gently push nail cuticle back (from fingers or toes) with cuticle or orange stick to prevent hangnails.

  Note: A clean washcloth can be used for this step. DSP can demonstrate these steps on his or her own nails.
- Teach and assist the individual to clean under the nails (fingers or toes) with orange stick or tool on nail clipper for this purpose.
- Teach and assist the individual to change the water and wash, rinse, and dry his or her hands or feet.

  Note: Do not rinse in soapy water.

  Why? Soapy water has many germs from the nails. This will prevent skin on the hands and feet from chapping.
- Teach and assist the individual to use nail clippers or nail scissors to trim toenails straight across. Fingernails can be trimmed with a slight curve. Use an emery board or nail file to shape and smooth the nails.

  Remember: Individuals with diabetes need professional assistance for nail care.

Appendix 6-F: Shaving

Attention

Shaving steps can be used for facial, leg, or underarm hair.

- An electric razor should not be used in same room where oxygen is used.
- Electric razors should not be used around water.
- Check all types of razors for chips or rust on the blades.
- Always dispose of used razor blades.
- Use only an individual's personal razor.
- Supervise the use of razors closely for safe and correct handling before individual shaves independently.
- Encourage the individual to do as much for him or herself as possible.

Supplies

- Personal electric or other style razor
- Shaving cream and aftershave lotion
- Personal towel
- Sink or other clean water source
- Mirror

PROCEDURE

- Teach and assist the individual in locating the best place to complete his or her shaving. Use of a mirror is recommended for shaving the face or under the arms.

  Note: Depending on what part of the body one is shaving, a sink, bowl, bathtub, or shower may be more safe and functional.

  Why? Safety is important while shaving. The individual should be comfortable and sitting or standing securely.

- Teach and assist the individual to check his or her skin for moles, birthmarks, or cuts.

  If any changes are observed in the size, shape, or color of a mole or birthmark, the individual should be seen by his or her physician.

  Why? Shaving over these areas can cause bleeding and infection. Changes may indicate illness.

- Teach and assist the individual to open shaving cream and remove safety cap from razor (non-electric razor) or plug electric razor into outlet.

  Note: Again, safety is important. Shaving cream in an electric razor can be dangerous.

  Electric razors near water can cause injury or death.

Appendix 6-F (continued): Shaving

Shaving with Non-Electric Razor

- Teach and assist the individual to wash area to be shaved with warm, soapy water. (Face, underarms or legs)

  Why? Washing removes oil and bacteria from the skin and helps to raise the hair shafts so it will be easier to shave.

- Teach and assist the individual how to apply shaving cream or lather with soap.

  Note: Some soaps and shaving creams can be harsh on the skin, or an individual can be allergic to them. There are different brands on the market for sensitive skin. An electric razor may work better for an individual with skin allergies.

  Why? Shaving cream softens the skin and helps the razor glide over the skin to prevent nicking and cutting.

- If the DSP is shaving the individual, wear disposable gloves.

  Note: Refer to Appendix 6-B for directions on putting on disposable gloves.

  Why? To prevent spread of germs.

- Teach and assist the individual to use the fingers of one hand to hold the skin tight and shave in the direction the hair grows.

  Note: Shaving in the direction the hair grows makes a smoother shave and helps prevent irritating the skin. The DSP may want to role play or demonstrate this shaving step on him or herself.

- Teach and assist the individual to rinse the razor often to remove hair and shaving cream so the cutting edge stays clean.
- Teach and assist the individual to use short strokes around chin and lips on the face; front and back of knees on the legs; and under the arms.

  Note: Short strokes give better control of the razor and help prevent nicks and cuts.

- Teach and assist the individual to rinse off the remaining shaving cream and dry the skin with gentle patting motions.

  Why? Left-over shaving cream can irritate and dry the skin. Rubbing freshly shaven skin can be irritating.

- If shaving the face, offer the individual a mirror to inspect a job well done.

  Why? Taking pride in completing personal care skills increases self-esteem.

- Teach and assist with applying aftershave or skin lotion if individual chooses.

  Note: Alcohol in aftershave acts as an antiseptic for tiny nicks and cuts. It also has a cooling and refreshing sensation.

- Teach and assist the individual with cleaning razor and storing all shaving items.
- Teach and assist the individual to wash, rinse, and dry his or her hands after shaving.

Shaving with an Electric Razor

- Teach and assist the individual to safely turn on the electric razor. Explain the safety of shaving away from water.

  Why? Electrocutions can occur when electric appliances, including razors, come into contact with water.

- Teach and assist the individual to use a mirror while shaving the face or under the arms.
- Teach and assist the individual in using a gentle, even pressure as he or she moves the electric razor over the skin. Demonstrate how running one hand over the shaved area can locate missed hair.
- Teach and demonstrate how to clean hair from the blades as needed during the shave.

  Note: Be sure razor in turned off and unplugged each time the blades are cleaned. Why? Injuries can occur when the razor is turned on or plugged into an electrical socket. Cleaning the blades keeps them sharp and provides for a smoother shave.

- Teach and assist with applying aftershave or skin lotion if the individual chooses.

  Note: Alcohol in aftershave acts as an antiseptic for tiny nicks and cuts. It also has a cooling and refreshing sensation.

- If shaving the face, offer the individual a mirror to inspect a job well done.

  Why? Taking pride in completing personal care skills increases self-esteem.

- Teach and assist the individual with cleaning the razor and storing all shaving items.
- Teach and assist the individual to wash, rinse, and dry his or her hands after shaving.

Appendix 6-G: Assisting an Individual with Bathing and Perineal Care

Attention

When assisting with bathing or showering:

- Remember to check water temperature. It should be warm to the touch.
- Wash, rinse, and dry each body part to prevent chilling, exposure, and chapping.
- Inspect skin for signs of injury or changes in condition.
- Use soap sparingly and do not leave in water.
- Provide privacy and warmth for the individual.
- Talk about things of interest to the individual.
- Encourage the individual to do as much as he or she can for him/herself.
- Demonstrate and explain correct bathing or showering procedures.
- Be prepared with all supplies.
- Be sure your hands are washed and clean.

Supplies

- Clean basin, bathtub, or shower stall
- Robe or clean clothes
- Soap and soap dish or special skin cleanser
- Personal towel
- Personal washcloth
- Disposable gloves for perineal care

PROCEDURE

- Teach and assist the individual how to check the water temperature for warmth before beginning. (Place your wrist under the running water.)

  Why? To prevent a chill or a burn.

- Teach and assist the individual to wash his or her hands and wrists.

  Note: Use the method learned from Appendix 6-H. The DSP will have washed his or her hands as well.

- Teach and assist the individual to wash and rinse each eye. Begin from the inner corner of one eye (near the nose) and moving to the outer corner of the eye. Repeat this step on the other eye, using a clean corner of the washcloth.

  Why? Use different ends of the washcloth to prevent the spread of germs from one eye to the other.

- Teach and assist the individual to wash and rinse the face, neck, and ears. Use the soap to make suds. Use clean tap water to rinse. Be sure to wash and dry behind the ears.

  Note: Ask the individual if he or she wants soap or prefers a special cleansing product.
  Why? Some individuals have sensitive skin.

- Teach and assist the individual to wash and rinse one shoulder, underarm, and arm.

  Why? Beginning near the wrist prevents dripping dirty water (germs) from sitting on already cleaned wrists and hands.

- Repeat the previous step for the other shoulder, underarm, and arm.

- Teach and assist the individual to wash and rinse the chest and stomach. Check under the breasts and any skin folds as you go along.

- Repeat previous step for the back.

  Note: Make sure the skin is completely dry. Remember to teach and assist the individual to dry completely.

- Teach and assist the individual to wash and rinse hip and one leg.

- Repeat previous step for the other hip and leg.

- Teach and assist the individual to wash and rinse one foot.

- Repeat previous step for the other foot.

  Why? Moisture in the skin folds can result in cracking and the breakdown (infection) of skin. Moisture between the toes can result in cracking and infection.

Appendix 6-G (continued): Assisting an Individual with Bathing and Perineal Care

PROCEDURE: Perineal Care for Females

Bathing of the genitals (sex organs) and anal (rectum) area of the body, sometimes referred to as the "private parts."

- When teaching or assisting with perineal care, put on disposable gloves.

  Note: Refer to Appendix 6-B for directions on putting on disposable gloves. Why? To prevent spread of germs.

- Teach the individual to separate the folds of skin in her genitals, called the labia, and using suds and the washcloth, wash with one down stroke the sides of the labia. Using a different side of the washcloth, wash down the middle of the labia. Rinse from front to back..

  Note: Always wash from the pubic area (front of the genitals) to the anal area to prevent contaminating the urethral opening (where the urine comes out) with germs or bacteria from the anal area.

- Teach the individual to wash and rinse the anal area, moving front to back.

  Use a different part of the washcloth for each wipe.

PROCEDURE: Perineal Care for Males

Bathing of the genitals (sex organs) and anal (rectum) area of the body, sometimes referred to as the "private parts."

- When teaching or assisting with perineal care, put on disposable gloves.

  Note: Refer to Appendix 6-B for directions on putting on disposable gloves. Why? To prevent spread of germs.

- Explain to the individual to hold his penis and wash and rinse the tip. Always wash from the small opening (urethra) where the urine flows, outward or towards the end of the penis. Use a different part of the washcloth for each wipe.

  Why? To prevent spreading germs (contamination) of the urethral opening.

- Teach the individual to wash, rinse, and dry the shaft of the penis. Wash and rinse in the direction of the pubic area.

  Note: If the individual is not circumcised, be sure the foreskin is pulled back and wash, rinse, and dry the penis. Return the foreskin to its natural position.

- Teach the individual to spread his legs and wash, rinse, and dry the scrotum (the two sacks at the base of the penis). Clean between the skin folds in this area and under the scrotum thoroughly.

- Teach the individual to wash, rinse, and dry the anal area, moving front to back. Use a different part of the washcloth for each wipe. Dry area thoroughly.

  Why? Moisture between skin folds may cause cracking of the skin and skin breakdown.

Appendix 6-H: Handwashing

Assemble Equipment

- Soap (bar or liquid)
- Paper towels
- Warm running water
- Waste container.

- ▸ Standing away from sink, turn on faucet and adjust water temperature. Keep your clothes dry, as moisture breeds bacteria.

- ▸ Wet hands and wrists, keeping your hands lower than your elbows so water runs off your fingertips, not up your arm.
- ▸ Use a generous amount of soap, rubbing hands together and fingers between each other to create a lather. Friction helps clean.

- ▸ Continue to rub, push soap under your fingernails and cuticles with a brush or by working them in the palm of your hand. Use soap above your wrist about two inches.

- ▸ Wash for one minute.
- ▸ Being careful not to touch the sink, rinse thoroughly under running water.
- ▸ Rinse from just above the wrists down to fingertips. Do not run water over unwashed arm down to clean hands.
- ▸ Using a clean paper towel, dry from tips of fingers up to clean wrists. Again, do not wipe towel on unwashed forearm and then wipe clean hands.
- ▸ Dispose of towel with out touching waste container.
- ▸ If your hands ever touch the sink or waste container, start over.
- ▸ Using a clean paper towel, turn off faucet, which is considered contaminated. Properly discard towel.
- ▸ Apply lotion if hands are dry or chapped.

Student Resource Guide

7. Dental and Oral Health

Student Resource Guide: SESSION 7

Dental and Oral Health

OUTCOMES

When you finish this session, you will be able to:

- Describe major types of obstacles that keep individuals from having good oral health.
- Identify ways to help individuals who need assistance have healthier teeth and gums.
- Identify aids to help overcome physical obstacles to good oral health.
- Describe positive behavior supports that help reduce resistance to oral hygiene procedures.
- Keep simple records that help the individual make progress with dental hygiene procedures.

KEY WORDS

Bacteria: Germs or microorganisms which are always present in the plaque and saliva.

Decay: Cavities (holes in the teeth) caused by acid from bacteria. The acid dissolves the tooth enamel and roots of teeth.

Desensitization: A treatment technique where the individual is exposed to gradually increasing anxiety-provoking stimuli while relaxing, with the goal of eventually confronting the fear without the previously associated anxiety.

Generalization: Using a newly learned skill in whatever situation the individual needs or wants to use the skill.

Gum Disease: Red, swollen, and bleeding gums (inside skin of the mouth) are signs of infections. Pain is a late sign of mouth infection.

Mouth Care: Daily activities that create a clean environment in your mouth in order to reduce or eliminate infections of the gums and bone, and decay of teeth.

Mouth Prop: An object used to keep the mouth open while oral hygiene is performed.

Oral Health Care Plan: A guide the planning team can use to write down the disease prevention activities for the individual. The activities in this plan include not only brushing and flossing, but also the use of fluoride and other products to make teeth stronger and to fight gum infections.

Oral Hygiene: Mouth care.

Oral Hygiene Session: The time in an individual's daily routine when they attend to mouth care.

Oral Hygiene Skill Survey: A document the DSP can use to determine the oral hygiene skill level of the individual he or she is assisting and to keep track of improvements in the level of skill.

Plaque: A sticky, tooth-colored, and sometimes invisible layer of bacteria (germs) that grows on the sides of the teeth and below the gums.

Reinforcers: Rewards given after the successful performance of a desired behavior.

Shaping: Teaching a skill by reinforcing behaviors that appear closer and closer to the desired skill.

This session was contributed by the Center for Oral Health for People with Special Needs

Overcoming Obstacles to Dental Health

As a DSP you may oversee or provide the mouth care (**oral hygiene**) for individuals who have different kinds of special needs. You may also be caring for others who need assistance, such as children or elderly parents. The information in this session can be used to help them all. It will give you the knowledge, confidence, and ability to help individuals you are assisting develop good dental health and enhance their independence. When they have good oral health, it will improve the quality of both of your lives.

Individuals with disabilities are at risk for dental disease. They often do not know how, or are unable, to care for their teeth and gums. Obtaining the services of a dentist, getting to the dentist's office, and paying for care are often very difficult for the individual and the DSP.

Prevention of dental diseases is the best answer to these problems. *Prevention is best for the individual and for the DSP.* Prevention is the #1 priority! Maintaining dental health means the person can:

- Avoid cavities, gum infections, pain, or tooth loss.
- Chew and enjoy a wide variety of foods.
- Feel good about the way he or she looks.

Planning for Success

Identifying the Three Major Obstacles

When individuals have problems taking care of their teeth, it is necessary to identify factors that block good oral hygiene. Once the blocks or obstacles are known, plans can be made to remove them. Removing the blocks helps the individual to have a healthy mouth and to become as healthy and independent as possible in self-care. Here are three kinds of obstacles you may see.

1. Informational Obstacles
Some individuals do not know what causes gum disease or tooth decay. They do not know what products are needed or the best way to brush their teeth or how long to brush. Others may have no idea how to floss their teeth. They need careful teaching or demonstrations in order to learn good methods. This session will provide information on disease and actions to prevent disease.

2. Physical Obstacles
Some individuals understand what needs to be done and are willing to do it, but are not physically able. They may have cerebral palsy or other physical disabilities. They may use crutches or a wheelchair or be unable to leave their bed. Some may be able to participate partially in their own care, and the DSP must do the part that they cannot do. Sometimes a change in the dental hygiene aids, such as modifying the handle of a toothbrush or floss holder, can improve the individual's ability to use these aids independently. This session will describe methods and equipment you may use to help individuals participate in their care as much as possible. Also shown are ways to help them complete the steps they cannot complete independently.

3. Behavioral Obstacles
Some individuals are able to do most or all of their own dental care, but resist doing it. Their resistive behavior is a serious obstacle to care. Resistance may be a habit. Sometimes resistance is due to fear, or it can be a learned behavior. This session describes positive ways to help people change behavior and replace resistance with cooperation or independence in daily oral hygiene.

Every Person Needs an Oral Health Plan

This session describes how to use an **Oral Hygiene Skill Survey** and an **Oral Health Care Plan** to record progress, decide what to do next, and communicate the oral health plans to others involved in the individual's care. These worksheets, Appendices 7C and 7B respectively, are useful to plan and record progress toward oral health. These forms show what the individual can do. Once you know someone's skills and problems, the planning team can make a plan for teaching him or her new skills.

ACTIVITY

Identifying Obstacles to Good Oral Hygiene

Directions: Pair up with another DSP in the class. Discuss one of the individuals that you support who needs assistance with oral hygiene procedures. For each problem, decide together whether it is an informational, behavioral, or physical obstacle to good oral health.

Obstacles to Good Oral Hygiene

Obstacles	Informational?	Behavioral?	Physical?

A Healthy Mouth

With proper cleaning, care, and visits to the dentist, your teeth can last a lifetime. If you follow a daily routine of proper oral hygiene, you can chew your food better, avoid pain, and enjoy a clean feeling in your mouth. When you look in your mouth or someone else's, there are signs that indicate a healthy mouth.

A healthy mouth should have:

- Pink gums.
- Gums that fit tightly around all teeth.
- Teeth that are white, without any dark or broken areas.
- Teeth that are shiny and reflect light easily.
- Teeth that sit firmly in the mouth and do not wiggle.

An Unhealthy Mouth

In an unhealthy mouth, you see signs that indicate the gums have infections or teeth have become decayed.

Some of the signs are:

- The gums are red and swollen and tend to bleed easily.
- The gum has become loose and pulled away from the tooth instead of being tight against the tooth.
- Darkened areas are seen at the gum line where the tooth and gum come together.
- A tooth or teeth may be loose.
- Dark and soft areas are present on the teeth.
- Teeth may be broken or have holes in them.

It is **not** normal to have any of the signs listed.

Plaque is the major cause of tooth decay and gum disease. Plaque is a sticky, tooth-colored, and sometimes invisible layer of **bacteria** (germs) that grows on the sides of the teeth. Although they live in the mouth, these bacteria are harmful.

Diet And Dental Diseases

Bacteria in the plaque use sugar to make acid. It happens like this:

- When you eat sugar, the bacteria in your mouth eat sugar too.
- The bacteria change the sugar to acid.
- The acid stays in the sticky plaque next to the tooth and gums.
- In time the acid eats into the tooth and makes cavities.
- In time the acid irritates the gums and starts gum disease.

You can reduce the damage done by plaque by reducing the frequency of having sugar in your mouth and minimizing the use of foods that contain acids.

- The frequency of eating sugar should be reduced as much as possible. Using sugar-containing mints, gum, or lifesavers keeps sugar in your mouth a long time and allows the bacteria in the plaque to produce more acid over a longer period of time.

- Sugar eaten between meals is worse than sugar eaten with meals. Eat non-sugar snacks such as carrots or popcorn between meals.
- Sugar is contained in more foods than you realize. Read food labels and look for the sugar content. Some cereals and bread have high amounts of sugar. Many liquid medicines contain lots of sugar. Fruits contain sugar and citric acid which can also damage the teeth. Soft drinks and fruit drinks contain sugar.
- So-called "sugarless" drinks still contain acid. The acid can also dissolve the teeth.
- Foods that have sugar and stick to the teeth, such as honey or taffy, are worse than foods with sugar that don't stick to the teeth, such as drinks or jelly. The longer the food sticks to the teeth, the longer the bacteria have time to produce acid.
- Sweets must not be used as a reinforcer. If rewards are going to be needed regularly, then use a non-sugar food. Other reinforcers could be flavored mouthwash, a new flavor of toothpaste, or social rewards. You can consult an individual's planning team for ideas about other rewards to use.

Plaque and Dental Disease

When the bacteria in plaque are fed sugar, they produce sticky material and acids. The sticky plaque material holds the acids against the surface of the teeth. If there is enough plaque, it can feel fuzzy on your teeth. Rinsing with water or mouthwash does *not* remove the sticky plaque with the bacteria in it. For about twenty minutes after sugar is eaten, the acids that are produced by the bacteria can dissolve the teeth.

After acid attacks, the tooth enamel breaks down, forming a cavity. Also, the gum fibers which hold the gum tightly to the teeth are also destroyed, forming "pockets" around the tooth. The pockets collect more bacteria.

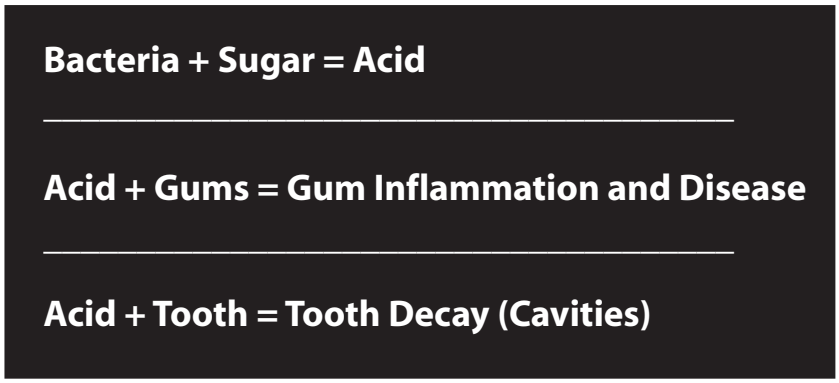


Figure 7-1 *summarizes the process of gum disease and dental decay.*

Where You Are Most Likely to Find Bacterial Plaque

You may have noticed that if you don't brush your teeth, the teeth feel fuzzy. What you are feeling are the bacterial colonies in the plaque as they grow on your teeth. Remember, plaque is tooth-colored or invisible. The first place that bacteria form is *along the gum line* and *in between the teeth* (Figure 7-2).

Most of the bacterial plaque we are trying to remove is found along the gum line where the tooth and gum meet; in between the teeth; on the inside or tongue side of the teeth; and especially, on the lower jaw.

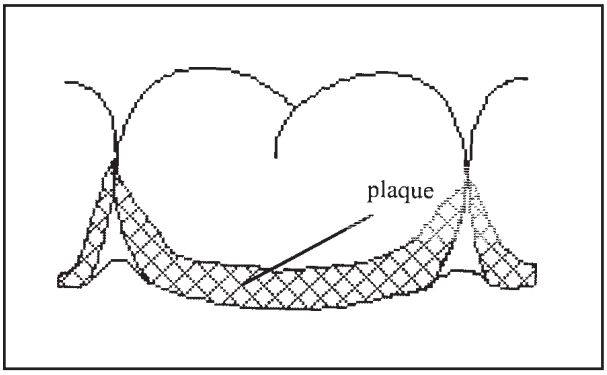


Figure 7-2 *The most common place for plaque to collect is along the gum line.*

ACTIVITY

Reducing Sugar in Individuals' Diets

Directions: Pair up with the person sitting next to you. Think about an individual you are assisting. Discuss his or her preferences for sweet foods, candy, and soft drinks throughout the day. List two changes that could be made at the grocery store or at the day or work program to reduce the time refined sugars are in the mouth. Write those changes down in the space provided below.

Changes

1. . . . . . .

2. . . . . . .

Overcoming Informational Obstacles

Plaque Removal

Good oral hygiene includes the removal of plaque. This means that the bacteria and the acids the bacteria produce are greatly reduced. The plaque bacteria must be broken up at least once every 24 hours by brushing and flossing the teeth. Even better, brush twice a day with a toothpaste containing fluoride.

Remember:

- Plaque sticks to teeth and usually is tooth-colored and hard to see.
- The plaque bacteria use sugars in food to live, multiply, and make acids.
- The acids and other irritating products inflame the gums and decay the teeth.

Toothbrush Selection

A good toothbrush has flexible bristles. These toothbrushes are called soft bristle brushes. They should have rounded, polished ends. Toothbrushes should be replaced when the bristles become bent or frayed. Most toothbrushes reach this state in three or four months. An electric toothbrush may help some people be more independent. Some individuals will be more willing to brush with a powered toothbrush.

The Oral Hygiene Session

The **oral hygiene session** is the time in an individual's daily routine when they attend to mouth care. These are major goals of the oral hygiene session:

- To prevent diseases of the gums and teeth.
- To help the individual you are assisting to become as independent as possible in self-care.
- To make oral hygiene part of daily grooming.
- To disturb the bacteria and remove plaque from the teeth by brushing and possibly flossing.
- To make each hygiene session positive and successful, thereby increasing positive behavior.

Each Individual's Program Will Be Different

For one individual you may need to modify a toothbrush or find the best position for brushing. For another, you may need to provide information about dental health or use behavioral methods to overcome resistive behaviors. It is important to know the individual and his/her oral health PPP goals and oral health care plans.

What to Brush

Think of the teeth as several small blocks sitting in a row. Each block, or tooth, has five sides to be cleaned: the cheek or lip side; the tongue side; the top or chewing surface; and the two ends.

The ends are where one tooth sits next to another tooth. It is important to remove the plaque by cleaning all five sides each day.

How to Brush Teeth

Step 1: Wet the toothbrush in water. Toothpaste is not necessary for plaque removal but can strengthen the teeth if it contains fluoride. Not using toothpaste reduces the need to spit and rinse.

Step 2: Place the bristles of the toothbrush half on the tooth and half on the gum. Turn the bristles to a 45-degree angle to the teeth (Figure 7-3).

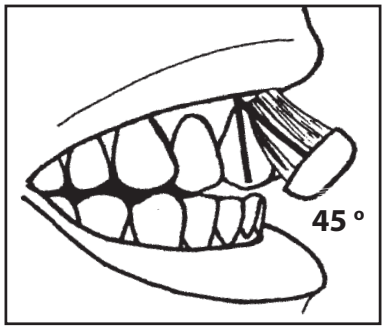


Figure 7-3 *The proper angle for brushing.*

Step 3: With a small circular motion brush both tooth and gum. Start by brushing the outside (cheek side) and inside (tongue side) of all teeth. Also brush the chewing surfaces. The individual should work up to at least 20 seconds in each of these areas for a total brushing time of at least two minutes.

Remember: *It is the brush that removes plaque. Toothpaste is not necessary to remove plaque. However, toothpaste can strengthen the tooth enamel if it contains fluoride.*

How to Find Plaque

Plaque is tooth-colored and very hard to see. You must color it, to make it visible to yourself or to the individual you are helping. Coloring tablets and liquids (disclosing solution) are available at drugstores.

How to Color Plaque on the Teeth

- Inform the individual you are assisting about the purpose of coloring the plaque on the teeth. Read the directions on the packet.
- Have the individual chew the tablet or paint the coloring liquid on their teeth as directed.
- Rinse with water, spit out, and wipe the lips.
- Look at the teeth in a bright light. Colored areas on the teeth show where the plaque is located.
- Usually, plaque is found along the gum line, on tooth surfaces next to the tongue, and on the chewing surfaces. It is easy to miss these places when brushing.
- Have the individual brush off the color with a toothbrush or help them to do so.

Color the plaque on teeth every other day until you know the places missed when brushing. Then once a month color the plaque on the teeth to check on brushing.

Remember: *When you or the individual you are assisting needs help seeing where plaque is located, start slowly. Some people may be frightened by the red color. Color only three or four teeth at a time. Show them how the color can be brushed off. Explain why you are using the color*

Removing Plaque Between Teeth

Brushing does not remove plaque bacteria on the two ends of the tooth. Remember, the ends are where one tooth sits next to another tooth. Flossing is needed to rub off the plaque at the ends of the teeth. Flossing takes practice for most people. Practice on yourself before flossing someone else's teeth.

Step-by-Step Flossing

Step 1: Take 18 inches of floss and wrap it around the third finger of each hand. Wrap the floss until there is about one inch between the two index fingers.

Step 2: Hold the inch section taut for more control. Slide the floss in a see-saw motion, gently between the teeth until it reaches the gum line.

Step 3: In order to rub the bacteria off the end of the tooth, wrap the floss around the end of the tooth, then rub the floss up and down. You may hear a squeaky sound when the end is clean. Then lift the floss over the gum so you can clean the end of the other tooth.

Flossing aids can be of help to people who do not have good finger or hand control. Clean floss is moved into place by pulling it along the floss aid. Check at your drug store to see what special flosses or floss holders might make the job easier.

Wear protective glasses when flossing someone else's teeth. The bacteria in the plaque can become airborne.

Helpful hint: *Introduce flossing very gradually to people you are helping. Floss only one or two teeth at first. The front teeth are easier to do. Stop the session at the first sign of tiring or resistance. End on a positive note.*

Cleaning Dentures or Removable Teeth

Wearing dentures or artificial teeth is not a signal to ignore brushing or cleaning. Bacteria and food build up on them, too. Soaking them overnight is not enough to clean them. Dentures, partial dentures, and artificial teeth must be brushed daily to clean off plaque bacteria. Evening is usually the best time to clean them. Remove dentures at night to let the tissue rest.

Dentures can break or warp. Leaving the denture out to dry all day or all night warps it. To prevent warping, always keep the dentures in a container covered with water or denture-cleaning liquid.

To clean partials and/or the dentures and prevent breakage:

Step 1: Put a washcloth in the bottom of the sink and fill the washbowl half full of warm water.

Step 2: With a soft toothbrush and baking soda, or denture powder, brush the inside and outside denture surfaces. Rinse the dentures in cool running water.

Step 3: For removable teeth or partials, brush the partials, especially the clasps, at least once a day.

Step 4: Have the individual you are assisting brush his or her teeth and gums. Pay attention to the teeth where the metal parts of the denture rest on the natural teeth. Brush that area carefully.

Very important: *Before putting the dentures in the mouth, inspect the mouth for red or irritated places on the gums. Some individuals may not be able to tell you if dentures are ill-fitting or uncomfortable.*

Do not use abrasive household cleaners on dentures. Do not use chlorine solutions on dentures or partial dentures.

ACTIVITY

Brushing Teeth Correctly

Directions: Turn to the person sitting next to you. Think about an individual you are assisting. Discuss how that individual brushes his or her teeth. What does he or she do independently or need to learn in order to brush correctly? Correct the angle of the toothbrush on tooth and gum? Brush more areas in the mouth? Brush longer? Cooperate with flossing? Something else?

Preventing the Spread of Germs

Saliva and blood in the mouth (from bleeding gums) commonly have germs in them. To prevent spread of germs from individual to individual or to the DSP, use standard precautions, including hand washing and the use of disposable gloves when handling dental supplies and helping with oral hygiene.

Proper storage of dental supplies prevents the spread of germs. Each individual should have a container with a lid or zipper to hold his or her toothbrush, floss, toothpaste, floss holder, mouth prop, and the like. The container should have small air holes to help dry the toothbrush between uses.

The individual's name should be on the container. Each individual's container should be stored separately. Do not store different individual's toothbrushes in the same container.

Steps to Prevent Infection During Oral Hygiene

Consider taping the "Steps to Prevent Infection During Oral Hygiene Procedures" sheet, which can be found in Appendix 7-D, to the bathroom wall where you can see it as you work with those individuals you are assisting with oral hygiene procedures. The steps include:

Step 1: Put out supplies needed before starting.

- Toothbrush.
- Paper tissues.
- Two cups of water.
- Disposable latex gloves.
- Safety glasses for helper (from hardware store).
- Toothpaste, if used.
- Mouth prop, if used.
- Floss and floss holder, if used.
- Disclosing tablets, if used.
- Timer.

Hint: *If you are using prescription fluoride or mouth rinses that are kept in a cabinet, get them out before starting the oral hygiene session.*

Step 2: Direct the individual you are assisting to wash his or her hands with soap and water. Also, wash your hands with soap and water.

Step 3: Put on protective eyeglasses if you are not wearing your own glasses. Put on a pair of latex gloves. They should fit well so you can handle the toothbrush or other supplies. Gloves must be worn whenever you may come into contact with another individual's saliva during the oral hygiene session.

Step 4: Before you touch the individual you are assisting, be sure you can reach all the supplies.

Steps to Prevent Infection During Oral Hygiene (continued)

Step 5: Start the session. Encourage the individual you are assisting to brush to the best of his or her ability. Then finish the job, if necessary, by doing what he or she is unable to do. If you or the individual is flossing (or using a floss holder), then do not use that floss in other individuals' mouths.

Once the gloves have been on the toothbrush or in the mouth, there is invisible blood or saliva on them. From then on, there are only two places where the gloves can be:

- In the mouth of the individual who is being helped.
- In a trashcan.

If you need more supplies or are interrupted, remove the gloves so you do not pass blood, saliva, or germs to the clean supplies or to other objects. Throw the gloves in the trashcan. Put on a new pair when you return.

When the oral hygiene session is finished, do the following:

Step 6: If the individual you are working with is able to, have him or her rinse the mouth with water from one cup. Swish the toothbrush in the other cup to remove toothpaste and bacteria. Throw the cups in the trash. If the individual is unable to rinse, consider not using toothpaste.

Step 7: Without touching any other objects, return the toothbrush and other supplies to the container. Have the individual you are assisting wipe his or her mouth. Throw the tissue in the trash.

Step 8: Remove your dirty gloves.

Step 9: Put the dental supplies container away.

Step 10: Have the individual you are helping wash his or her hands with soap. Wash your hands. Thank them for a positive session.

Other Ways to Prevent Tooth Decay

We now know that several factors can cause cavities. Knowing this gives us a number of ways we can protect our teeth from cavities. There are practices that protect the teeth and conditions that cause teeth to dissolve and form cavities. Your job is to have an environment in your mouth (and in those for whom you are responsible) where the positive protective factors are in place *as many hours a day and night* as possible. Your goal is to have the cavity-causing or negative factors in place for as little time, or as few hours a day, as possible.

Some of the protective factors that keep teeth and gums healthy are:

- Having fluoride on the teeth daily.
- Using fluoride varnish, Xylitol, as needed.
- Reducing bacterial plaque on the teeth.
- Adopting a healthy diet low in sugar.
- Good saliva flow.
- Professional cleanings and examinations.
- Minimizing the amount of time sugar foods, candy, or drinks are in the mouth.
- Having a neutral (not acidic) mouth condition.

Some of the factors that contribute to the cause of cavities are:

- Frequent exposure to sugar.
- Feeding sugar to your bacteria to produce acid (especially between meals).
- Dry mouth or very little saliva.
- Passing cavity causing germs from caregivers to children (tasting food, sucking on pacifier, and kissing, for example).
- Unhealthy diet.
- Lack of fluoridated water.
- Lack of professional oral health care.

See Appendix 7-A for a list of products that can help prevent tooth decay.

Overcoming Physical Obstacles

Encouraging Participation

It is important for each individual to participate as much as possible in his or her own care. Sometimes, to get rid of plaque it may be necessary for the caregiver to finish brushing someone's teeth, *but the individual should first do what he or she can*.

Some individuals can gradually learn to perform oral hygiene. Others will learn some skills, but will participate only partially in their care. Others will be unable to participate. *It is the DSP's role to help each individual be as independent as possible while at the same time being sure that he or she has good oral hygiene.*

Adaptations of Oral Hygiene Aids

Adaptations of oral hygiene aids can make it possible for some individuals to be more independent in self-care. Individuals with hand, arm, or shoulder limitations may be helped by these changes. Consult with the individual's dentist for suggestions and before making any changes. See Figure 7-4 for some examples of oral hygiene instruments that have been adapted to increase individual participation.

To adapt a toothbrush or floss holder to make it easier to grip:

- Enlarge the brush handle with a sponge, rubber ball, or bicycle handle grip.
- Lengthen the handle with a piece of wood or plastic, such as a ruler or wooden tongue blade.
- Bend the toothbrush handle. To bend it, run very hot water over the handle, not the head, of the brush.

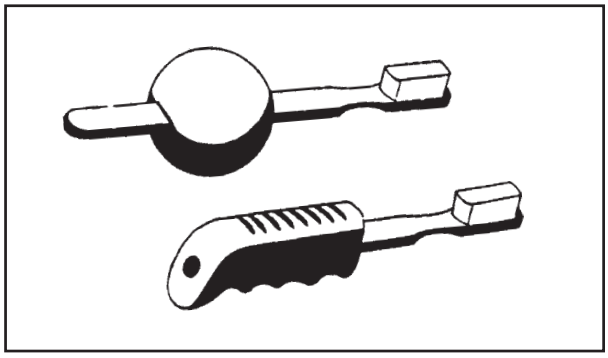


Figure 7-4 *Examples of adapted toothbrushes.*

Restraint vs. Help

Individuals with severe physical or other disabilities may require that the DSP do what they cannot. Sometimes this means that the DSP must move the individual, position them, and then perform dental hygiene procedures for them. It is important that the individual view the process as helpful. You must follow local, state, and federal laws and guidelines to be sure the individual is not restrained against his or her will. The remainder of this session will assume that an individual who is partially able to perform oral hygiene procedures desires assistance to completely remove plaque from the teeth.

Location

If the individual you are assisting needs only a little help, then use the bathroom. The bathroom, however, is not a good place if more than a little help is required. In the bathroom, it is often hard to see, keep the mouth open, and get to all areas in the mouth. If someone needs a lot of help, it can be easier to do so somewhere else. Other places where tooth brushing or flossing can be done include a wheelchair, a bed, or a living room couch.

If toothpaste is not used, there is no need for rinsing and spitting. Actually, all that is needed is a toothbrush that has been moistened slightly with water to soften the bristles. To get the benefit of fluoride in toothpaste, it can be applied in the bathroom later, after the plaque has been removed. Toothpaste is not necessary to remove plaque.

Mouth Props

Sometimes, dental professionals will recommend that a mouth prop be used for an individual who has trouble keeping his or her mouth open. A **mouth prop** is an object used to keep the mouth open while oral hygiene is performed. **Do not use a mouth prop without a written order and without training in its use from a dental professional.**

Positioning

Depending on the positioning needs of the individual you are working with, one of the following ideas may help:

Wheelchair or Chair

The caregiver stands behind the individual in the wheelchair or chair. The caregiver leans over, supports the individual's head from behind, and cleans the teeth (Figure 7-5). The head can be held steady. This position works well for some individuals, but not for everyone. You may have to experiment to find a comfortable position for you and for the individual you are assisting.

Figure 7-5 *Using a chair to assist with tooth brushing and flossing.*

Couch, Bean-Bag Chair, Recliner, or Bed

This position works well for individuals who need maximum assistance. The individual needing assistance is on his or her back. The DSP sits at the person's head, or better, the head is on a pillow in the DSP's lap. The DSP's left hand can be used to steady the head while cleaning with the right hand (Figure 7-6). This position can be more comfortable for the DSP's back than other positions.

Figure 7-6 *Using a couch to obtain proper positioning for dental hygiene.*

Experiment with Other Positions

Try for positions that allow you to see into the mouth, control the head, and protect your back.

Remember: *Toothpaste is not necessary, but it does provide topical fluoride. Rinsing and spitting are not needed when only a moist toothbrush is used. The better you can see, the better the job you can do.*

ACTIVITY

Positioning

Directions: Pair up with another person in the class. Use a chair and the floor to practice positioning your partner to perform oral hygiene procedures. What is the best position to see into the mouth?

Overcoming Behavioral Obstacles

Create an Environment that Works

Some individuals have had a negative history with tooth brushing or are sensitive to being touched. This can result in behavior that makes it particularly difficult to do oral hygiene procedures. Some environmental factor or factors may be causing the resistive behavior. DSPs should use their observation tool to determine which environmental factors cause resistance and try to remove or minimize them.

Some common environmental factors that can increase resistance to oral hygiene are listed below:

Frequent or Unexpected Changes in Routine

- If someone doesn't know what to expect, or if change is upsetting, resistance can be a response. Having a set routine, or explaining the changes that are coming, may reduce resistance.

Wrong Time of Day

- Some individuals don't function well until they have had the first cup of coffee. For them, morning may be the wrong time of day to learn a new skill.
- Reduce the risk of a problem by scheduling tooth brushing when the individual is most alert or not hurried.

Boredom

- The individual is tired of doing the same thing each day.
- Novelty helps maintain interest and attention. A change in the color or flavor of the mouthwash, a new cup, some background music, or a change in routine may increase cooperation.

Unpleasant Associations

- Sometimes an individual has associated a DSP with the tooth brushing activity. The sight of the person triggers resistance. A change in caregiver for tooth brushing may prevent resistance. Other things can have unpleasant associations for the person, such as a particular mouthwash or another individual who is present and distracting.
- Watch for situations (large and small) that may upset the individual you are assisting and make appropriate changes.

Distractions

- Some objects in the tooth brushing area may attract the individual you are working with more than the toothbrush. If distracted, he or she may not want to use the toothbrush.
- Interruptions by other persons can be serious distractions.
- During a lesson, keep all distractions, including other people, out of the area.

Overcoming Behavioral Obstacles

Nagging

- Everyone tends to become resistive when told too many times to do something. Repeated reminders can also increase anxiety.
- Talking less and praising more can reduce resistance.

Ignoring an Individual's Needs or Interests

- If an individual is in the middle of a pleasant activity, it is risky to demand that he or she leave it to brush his or her teeth.
- Try to schedule tooth brushing at a time when it will not interrupt other activities.

Interrupted Instruction

- A tooth brushing session may last five to ten minutes. Don't leave to answer the phone or to check on dinner.
- Instead, set a time that allows for completion of the activity and remind the individual you are assisting, at intervals, that the time is almost up. Suggest that he or she can return to the activity after the oral hygiene session. One good brushing per day is better than several incomplete brushings.

Carefully watch the individuals you are assisting for a few days to see at what point they become resistive. By noting what happens just before the resistance, you may uncover the environmental factor or factors. You can then plan ahead for a low-risk oral hygiene session. You will accomplish two things:

- Both you and the individual you are helping will have a successful tooth brushing session.
- The chance of challenging behaviors is reduced. The likelihood of success increases the longer someone goes without resistive behaviors.

Be prepared to prevent challenging behaviors rather than reacting to them.

ACTIVITY

Reducing Resistance to Oral Hygiene

Directions: Consider one of the individuals you assist who resists oral hygiene. Think about what happens just before they become resistive. Write down what environmental factors may trigger the behavior in the space provided below. Then write down what strategies could be tried to change the environment to promote success.

Environmental Factors	Strategies

Involving the Individual

When you believe a job is worth while, feel responsible for doing it, and control how it is done, you tend to become actively involved with the job. Once involved, you work hard to do a good job. You feel you own the job.

Your challenge is to help individuals you are assisting with oral hygiene procedures to become actively involved in their own oral hygiene. Help them take ownership of the job.

Here are three ways to help individuals become active participants in oral hygiene:

1. Encourage them to make choices.

Making a choice and having it fulfilled is very satisfying. The satisfied person becomes involved with the activity. Having choices can reduce problem behaviors. Limit choices to those related to the activity at hand.

Ask the person you are assisting: "Do you want Crest or Colgate?" "Do you want to sit or stand?" "Do you want to start with your upper teeth or lower teeth?"

You are not asking if he or she wants to brush or not. You are offering choices that promote responsible participation. Other choices could be the time of day to brush teeth, a change of toothpaste, or a new toothbrush.

2. Allow the individual to set limits to participation.

When individuals can decide to stop the oral hygiene session, they develop a feeling of control and of ownership of the activity.

This is tricky. They may stop their participation before the brushing is really underway. Yet, if you don't allow them to stop the activity when they have had enough, you may have to deal with resistance.

Teach limit-setting in a gradual manner. Notice how long it takes for the individual to become fussy or resistive; is it immediately, 30 seconds, 3 minutes? Then allow him or her to end the session a few seconds or minutes before resistance is to be expected.

> ***Example:*** *If Jean always has tantrums after 60 seconds of tooth brushing, allow her to stop brushing after 30 seconds. Next time, allow her to stop brushing after 45 seconds. The next time, 60 seconds. You are teaching Jean she has some control and does not have to have a tantrum to stop the session.*

What if the individual you are helping becomes resistive before you start? Make the steps smaller. Allow him or her them to end the session after completing one tiny step.

> ***Example:*** *Ben can stop the activity after he holds the brush for 3 seconds. The next time, he must hold it for 5 seconds. Eventually, he must put the brush in his mouth before he can stop the session.*

3. Make sure they achieve success.

Success is almost certain if the steps the individual is asked to learn are small, and the process is gradual.

End each session on a successful note.

Gradually, as the individual comes to feel oral hygiene is his or her job, he or she will become a willing and active participant.

***Remember*:** *Involve the individuals you are working with by:*

- *Encouraging them to make choices.*
- *Allowing them to set limits. Teach limit setting in a gradual manner.*
- *Making sure they achieve success. End each session on a successful note.*

ACTIVITY

Choices

Think about the same individual that you described as resistive after reading the last chapter. Write your answers to the following questions.

Are there any choices that individual could make during tooth brushing activity?

What is an acceptable way he can tell you he would like to end the activity?

Behavioral Support Strategies

Several strategies can be used to help support an individual who seems resistant to completing his or her oral health care. It is always important to first determine if there are physical, medical, or informational barriers that prohibit the individual from communicating or completing oral hygiene procedures. Be sure to ask a lot of questions and to get a thorough history to find out if any of these barriers apply. Once you have ruled out these barriers, you may want to try one of the following behavioral support strategies or consult with a behavioral specialist to develop an appropriate plan for the individual:

- **Reinforcers**: Reinforcers are given after the successful performance of a desired behavior.

  Example: *If Mary brushes her teeth for two minutes, she will receive a reward. Remember, you must have a clear idea of the behavior you are trying to reinforce, use the reward only when the behavior is performed, and be sure the reinforcement occurs directly following the desired behavior.*

- **Shaping:** Shaping is the reinforcement of small parts of a task. This is followed by reinforcing for larger parts until the individual can perform all of the task or has reached the highest level possible.

  Example: *You learned to brush your teeth step-by-step. First, you learned how to hold a toothbrush and put toothpaste on it. Your parents or caregiver's approval was the reward as well as your sense of accomplishment. Next you began to put the brush in your mouth and move it around. At each step you received praise and approval. These rewards encouraged you to learn to brush your teeth one step at a time and shaped your tooth brushing ability from holding the toothbrush to successfully brushing your teeth.*

- **Generalization:** Generalization is a way to help an individual overcome fears by offering objects or activities somewhat like those used in oral hygiene procedures.

  Example: *If an individual won't let anything touch his lips, then offer a desired drink through a straw or a sugarless lollipop. If he won't let anyone look in his mouth, he might be encouraged to look in his own mouth with a mirror.*

- **Desensitization:** Desensitization is a treatment technique where the individual is exposed to gradually increasing anxiety-provoking stimuli while relaxing, with the goal of eventually confronting the fear without the previously associated anxiety.

  Example: *If the individual is fearful of a dental visit, he or she can slowly be introduced and desensitized to each step of the visit, such as driving to the office, sitting in the waiting room, meeting the receptionist, sitting in the dental chair, meeting the dentist, touching the dental equipment, having the dentist look in his or her mouth, and counting teeth. The individual has control over this process and would indicate any sign of fear or discomfort. He or she would be instructed on ways to relax until he or she could move through the steps of the visit free of anxiety or fear.*

Most of these strategies are easy to use; however, they do require creativity, patience, and time for implementation. The results, however, can be very rewarding to you and to the individual.

Not only will the individual feel good about his or her accomplishments, you will have helped that individual to take better care as independently as possible—something you can be very proud of.

ACTIVITY

Behavioral Support Strategies

Directions: Pair up with another student. Describe someone you have worked with that might benefit from one of the behavioral techniques listed and how you might implement that technique.

Putting It All Together

Making a Plan

Individuals have plans for medical, social, recreational, educational, and grooming activities. **Oral health care must be part of an individual's daily plan.** Improving oral health involves a step-by-step process that requires planning, carrying out the plan, and then re-planning. Every individual needs an updated oral health plan.

You now have the information you need to assist the planning team to develop oral health care plans for the individual you are assisting. Use the Oral Hygiene Skill Survey and Oral Health Care Plan, Appendices 7-B and 7-C, respectively, to help you.

Using the Plan

- It is important to include the Oral Health Care Plan with the Individual Program Plan and other plans for that individual's care. Keep the Oral Hygiene Skill Surveys and the Oral Health Care Plans in the folder you use to keep other care plans. That way, you can always look back to see where progress is being made and where an individual needs more work.
- Go over the plan with everyone on the individual's planning team. Demonstrate what to do. It is very important that everyone teach in the same way. Post the current plan where everyone can see it when working with that individual.
- Review the entire program with everyone involved once a month so the Oral Health Care Plan becomes a regular part of the care of that individual. Do this until the individual has become as independent as possible in self-care.

If you are successful with the training program, then the individual you are assisting may be able to use his or her new skills in other settings, including a dental office.

See Appendices 7-B and 7-C for detailed instructions on how to fill out the Oral Hygiene Skill Survey and the Oral Health Care Plan.

Making It All Work

The knowledge you have gained during this session will only be useful if you use it. This means you must do everything you can, based on the training, to improve the oral health of the individual you are assisting. Therefore, starting now, you should be doing at least the following:

- Determine what the barriers are to better oral health for each individual.
- Use the Oral Health Care Plan to help the planning team make oral health care plans for each individual you assist. This involves a cycle of planning, carrying out the plan, checking progress, and revising and communicating the plan as needed.
- Directly participate, in the bathroom or elsewhere, with the individual during oral hygiene sessions until you are sure he or she is as independent as possible in oral care. Some individuals will always need your help to have good dental health. Don't assume he or she is doing a good job without checking.
- Use standard precautions, including proper storage of tooth brushing supplies, wearing of disposable gloves, and protective glasses when flossing.
- Coach the individual using the positive behavior support skills that you learned in this session. These include structuring the environment to maximize the chance of success; involving the individual in the process; using reinforcers; using shaping techniques; generalization; and desensitization.
- Try to get individuals to brush all surfaces of their teeth (inside and outside of front and back and the chewing surfaces); use proper brushing techniques; and increase the time of tooth brushing until they are brushing for at least two minutes.
- Use the Oral Hygiene Skill Survey for each individual to record progress.
- Revise the individual's Oral Health Care Plan based on the individual's progress. Communicate the plan for improvement to others who work with that individual.

- If there are areas that individuals aren't brushing well, help them brush those areas by using physical adaptations, different positions, or partial participation if necessary.
- If an individual just cannot clean certain areas in his or her mouth, even with your help, consider using products with Xylitol or getting a prescription for a chlorhexidine or fluoride mouth rinse to help decrease plaque.

This session has given you the knowledge and techniques to help individuals you are assisting develop good oral health and enhance their independence. Good oral health will improve the quality of both of your lives.

ACTIVITY

Using What You Have Learned to Overcome Obstacles

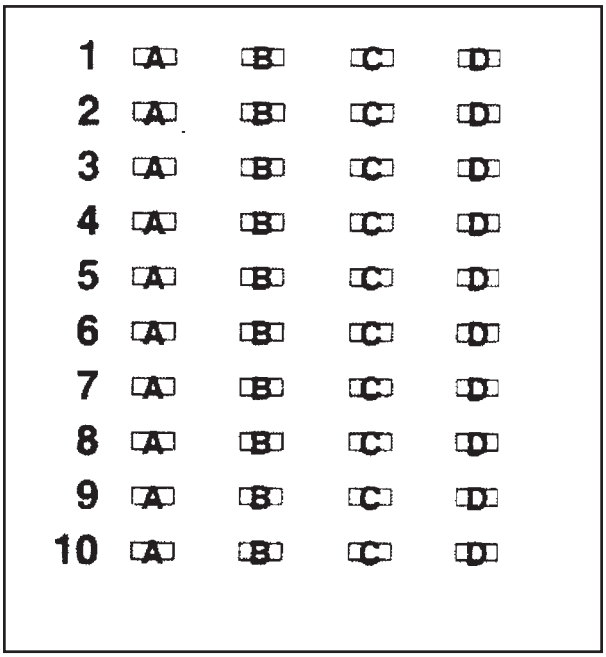
Directions: Review the following scenario. Each group will be given a piece of flipchart paper and a marker. Brainstorm and write down all of the things that Mary can do to assist Andrew.

Andrew does not like to brush his teeth. Every time Mary tries to get him to do it, Andrew throws the toothpaste and toothbrush in the garbage, runs to his bedroom and slams the door. Mary is concerned about his dental health. Some of Andrew's teeth are discolored and his gums are swollen and red. Mary has told him that his teeth will fall out if he doesn't brush them every day. However, that fact doesn't seem to influence Andrew enough to make him do it. Mary wonders if she should force Andrew to brush his teeth even if he throws a tantrum. How can she help Andrew to see how important it is to take care of his teeth?

PRACTICE AND SHARE

In this session, you learned strategies for overcoming different obstacles to individuals' dental health. Think of an individual in your home who is resistant to the oral hygiene session. Give the individual one or two choices during oral hygiene sessions. Pay attention to the result of giving them some choices. At the beginning of the next session, the class will discuss their experiences.

Dental Health



1. **Whenever someone you are assisting is told to brush her teeth, she refuses to open her mouth. This is an example of what kind of obstacle to tooth brushing?**
   A) Physical obstacle.
   B) Behavioral obstacle.
   C) An informational obstacle.
   D) All of the above.

2. **You are assisting someone who is not physically able to brush her teeth, but she will accept your help. You should:**
   A) Use behavioral techniques to change her behavior.
   B) Use partial participation where you do the parts she cannot do.
   C) Show her the proper way to brush.
   D) Offer her rewards for brushing.

3. **The physical form of the sugar can make a difference for the teeth. Which type of sugar is hardest on the teeth?**
   A) A cookie.
   B) A chewy sticky candy like caramels.
   C) A piece of angel food cake.
   D) A glazed donut.

4. **When an individual's mouth shows swollen gums which bleed easily when brushed, the situation is most likely:**
   A) Caused by brushing too long with a soft brush.
   B) A sign of healthy gums.
   C) Caused by a lack of sugar-free sweets in the diet.
   D) A sign of unhealthy gums.

5. **The following is a way to increase the protective factors in the mouth:**
   A) Keeping your mouth sugar free as many hours per day as possible.
   B) Limiting the frequency of snacking between meals and sugar soft drinks.
   C) Using toothpaste with fluoride.
   D) Brushing your teeth for two minutes twice a day .

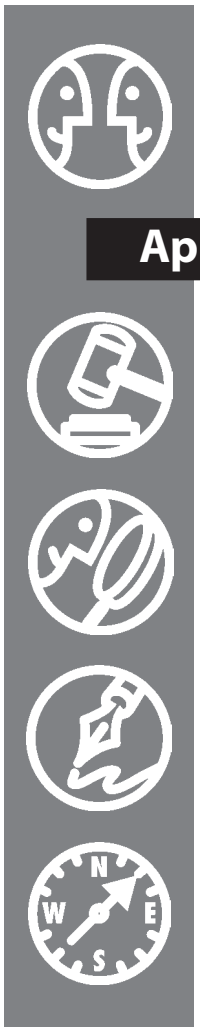
6. **A DSP may brush an individual's teeth for them, if:**
   A) This does not occur more than once a day with that individual.
   B) The DSP is of the same gender as the individual whose teeth are being brushed, or a witness of the same gender as the individual is present.
   C) The individual first did whatever part of the brushing they can do themselves.
   D) The brush handle is enlarged with a rubber ball or bicycle handle grip.

7. **By watching to see at what point the individual you are assisting becomes resistive to oral hygiene:**
   A) You identify the informational obstacles.
   B) You learn what the individual likes.
   C) You may identify the environmental factor that triggers the individual's resistance.
   D) You identify the physical obstacles.

8. **To prevent "escape" behavior during oral hygiene:**
   A) Stop the activity immediately after the resistive behavior occurs.
   B) Stop the activity 2 minutes after the resistive behavior occurs.
   C) Stop the activity moments before the resistive behavior usually occurs.
   D) Don't stop the activity.

9. **The score given to the steps on the *Oral Hygiene Skill Survey* represents:**
   A) The number of attempts to remove plaque in each area of the mouth.
   B) The number of times that the caretaker needed to remind the individual to do each step.
   C) The degree of independent performance or assistance, which is needed for each step.
   D) How clean the teeth are after a tooth brushing session.

10. **The purpose of the *Oral Health Care Plan* is to:**
    A) Record the oral care steps being taught.
    B) List what reinforcers are now being used.
    C) Record schedules for such activities such as flourine use or dental examinations.
    D) All of the above.



Appendices

Appendix 7-A

Products That Can Help Prevent Tooth Decay

1. **Toothpaste**: Apply a fluoridated toothpaste accepted by the American Dental Association Council on Dental Therapeutics two times a day for two minutes. After the age of 12, or when a dental professional finds that gingivitis is present in an individual under 12 years of age, use a fluoridated toothpaste accepted by the American Dental Association Council on Dental Therapeutics that contains an approved effective anti-gingivitis agent. *Toothpastes are sold over-the-counter, and no diagnosis, prescription, or intervention is required from a dentist or other dental professional for their use.*
2. **Xylitol**: Use products containing xylitol three times per day and five minutes per exposure. If xylitol-containing chewing gum can be used, it should be chewed for five minutes, three times a day. Chewing may not need to be supervised to be sure the individual received the required exposure. For individuals who cannot chew gum, other xylitol products are available, such as mints and lollipops. For infants, the xylitol can be added to specially designed pacifiers or baby bottles with xylitol solutions. *Xylitol is a natural sugar added to many food products, and no diagnosis, prescription, or intervention is needed from a dentist or dental professional to use it.* Sample products include: Total®, Xylimax®, Advantage®, and XyliFresh®. For other products see the Oral Health Resource list at *www.dental.uop.edu/resource* .
3. **Fluoride Varnish**: Fluoride varnish can be applied in one of two ways:
   - ▶ Three times in one week (for example, Monday, Wednesday, and Friday), once per year.
   - ▶ One time every six months.

   A temporary yellowish tint to the teeth may appear for a short time after application, which may be of concern to some individuals. *Fluoride varnish must be applied by a dental professional although this does not need to occur in a dental office. Check with your dentist or dental hygienist for specific regulations regarding the application of fluoride varnish.*
4. **Fluoride Rinses**: For individuals who are not able to use the recommendations listed above, fluoride rinses can be of benefit to prevent cavities. Fluoride mouth rinse is currently an option for all people over the age of 6 who can **safely** "rinse and spit." If an individual cannot rinse and spit, the solution can be applied with a cotton swab twice a day. *Topical fluoride rinses (such as, Prevent® or Act®) are over the counter (otc) medications and require a prescription in licensed community care facilities.*
5. **High Concentration Fluoride Toothpaste or Gel:** When none of the above recommendations are working, consider daily or weekly use of high concentration fluoride toothpaste or gel. The decision to use these products should also consider the ability of the individual to spit, or of the caregiver to supervise and control the application. *These products contain toxic amounts of fluoride and can be harmful if they are not used and spit out properly. Consult with an oral health professional about use and the prescription required to obtain these products.*

6. **Chlorhexidine:** An antibacterial agent effective in reducing plaque formation and gum infection is chlorhexidine. It is sold under the name of Peridex® and Periogard®. *A prescription from a dentist or medical doctor is required.*

   If you have a prescription for chlorhexidine (Peridex®) use it as follows:

   - Set out the supplies you will need, including a timer.
   - Clean the teeth.
   - Swish chlorhexidine solution around the mouth for one minute then spit it out, or apply a small amount of the solution to the teeth with a cotton swab or toothbrush for one minute. Some dentists recommend using chlorhexidine in a spray bottle for some individuals who cannot rinse or spit.

   Chlorhexidine can have the following side effects:

   - Chlorhexidine can cause gray or brown staining of gums, teeth, fillings, or crowns. This stain can be removed by a dentist or dental hygienist.
   - Some people have small changes in taste. The changes are temporary.

Ways to Prevent Tooth Decay Include:

- Use products like toothpaste that contain fluoride or other helpful agents.
- Eat nutritious meals and limit snacking on sugary foods and sugary soft drinks between meals.
- See your dentist or hygienist every six months or more frequently if indicated.
- Have baby's first oral exam **before** his or her first birthday.

If the individual has dry mouth from medications or for other medical reasons, try rinsing with water after eating or having sweets, mints, foods, or drinks during the day. Talk to a dental professional about the possible use of a saliva substitute like Biotene®.

Appendix 7-B

Instructions for the
Oral Hygiene Skill Survey

The Oral Hygiene Skill Survey can be used to determine the oral hygiene skill level of the individuals you assist and to keep track of improvements in their level of skill. There is room to score seven different oral hygiene sessions. For some individuals who are learning new skills very quickly, you may need to score every day. For other individuals who are learning new skills very slowly, you may only need to score once a week.

There is a simple scoring system that is used with the Oral Hygiene Skill Survey. You score what the individual is unable to do, what he can do with your help, and what he can do by himself.

The Oral Hygiene Skill Survey uses a simple scoring system:

0 – Step is not done.
1 – DSP performs the step.
2 – Individual performs the step with prompts.
3 – Individual performs the step independently.

Fill out the Oral Hygiene Skill Survey as follows:

- A score of 0 is given if the individual is unable to do the step or is unable to complete the step.

One of the steps is "brush chewing surfaces of teeth." If the individual brushes the outside of the teeth and the tongue side of the teeth but does not brush the chewing surfaces at all, the score for "brush chewing surfaces of teeth" is 0.

If the individual brushes the chewing surfaces on the bottom teeth but not the top teeth, then he does not complete the job. The score is still 0.

- A score of 1 is given if the caregiver must complete the step for the individual.

If the individual mentioned above could brush the bottom chewing surfaces but was physically unable to twist his wrist to brush the upper chewing surfaces, and the caretaker had to brush that part for him, then the score is 1 for "brush chewing surfaces of teeth."

If an individual puts the toothbrush in his mouth and makes a few brushing motions, and the caregiver must finish, then the score for all the tooth brushing steps is 1.

- A score of 2 is given if the individual does the step after being prompted by the caregiver.

If the caregiver guides the individual's wrist so that he twists it up to brush the upper chewing surfaces and he does so, then the score is 2. The caregiver has given him a verbal prompt to help him complete the step.

> ***Hint:*** *If physical prompts are necessary, try to fade them to verbal prompts as the individual becomes more skillful.*

- A score of 3 is given when the individual can complete the step on his own.

Add up the scores and total them at the bottom of the sheet.

Look at each of the steps. Decide where you want to start or continue the training. Decide what the individual needs to learn next.

The goal is to coach the individual to become as independent as possible. After that, the DSP completes what the individual cannot do by him- or herself.

Oral Hygiene Skill Survery (sample)

Name *John* Caregiver Name *Bill* Start Date *10/29/03*

Client Behavior	***Dates***			***Comments and Behavior***
STEPS	*10/29*	*11/9*	*11/23*	
Tooth brushing	*3*	*3*	*3*	
1. Identify own brush	*3*	*3*	*3*	
2. Approach sink	*2*	*2*	*2*	*Need to point at brush and then sink to get him to wet it.*
3. Pick up and wet brush	*2*	*2*	*2*	*Have to tell him to put on toothpaste.*
4. Put toothpaste on brush	*2*	*2*	*2*	*Say "now put the toothbrush in your mouth."*
5. Put toothbrush in mouth	*1*	*2*	*2*	*Needs constant verbal praise.*
6. Keep brush in mouth for 5 seconds	*1*	*2*	*2*	*Needs constant gentle touch of hand or verbal praise.*
7. Keep brush in mouth for 1 minute	*1*	*1*	*2*	*Lie on couch for me to hold his mouth open.*
8. Keep brush in mouth for 2 minutes	*1*	*1*	*2*	*Lie on couch for me to hold his mouth open.*
9. Brush inside/outside front teeth	*1*	*1*	*1*	*Could not brush chewing surface on back side of right side.*
10. Brush inside/outside back teeth	*0*	*1*	*1*	*Will rinse if told to do so.*
11. Brush chewing surfaces of teeth	*1*	*2*	*2*	*Needed to point to brush holder at first.*
12. Rinse and spit	*2*	*3*	*3*	
13. Put toothbrush/toothpaste away	3	3	3	

Oral Hygiene Skill Survery • page 2 (sample)

Name *John* Caregiver Name *Bill* Start Date *10/29/03*

Client Behavior	***Dates***			***Comments and Behavior***
STEPS	*10/29*	*11/9*	*11/23*	
Flossing	*0*	*0*	*0*	*Not ready to have flossing introduced.*
1. Pull out 18 inches of floss	*0*	*0*	*0*	
2. Cut off floss	*0*	*0*	*0*	
3. Wrap floss around middle fingers of each hand	*0*	*0*	*0*	
4. Place both fingers on floss	*0*	*0*	*0*	
5. Hold inch section taut	*0*	*0*	*0*	
6. Slide floss in see-saw motion between teeth to gumline	*0*	*0*	*0*	
7. Wrap floss "C-shape" around tooth	*0*	*0*	*0*	
8. Move floss up and down	*0*	*0*	*0*	
9. Lift floss over gum, do other tooth end	*0*	*0*	*0*	
Total	*23*	*28*	*30*	

Scoring Key

0 = Step could not be completed
1 = Caretaker completes step for individual
2 = Need to prompt to complete step
3 = Can complete step independently

Comments:

We need to proceed slowly. We are making progress. The reward system is working well and so is the shaping, using small steps in allowing him to do more and more each time. We are working on letting him brush the insides of the lower teeth. We are also working on having him hold the brush in his mouth for a longer and longer time by himself or with a prompt.

Oral Hygiene Skill Survery

Name _____ Caregiver Name _____ Start Date _____

Client Behavior	*Dates*				*Comments and Behavior*
STEPS					
Tooth brushing					
1. Identify own brush					
2. Approach sink					
3. Pick up and wet brush					
4. Put toothpaste on brush					
5. Put toothbrush in mouth					
6. Keep brush in mouth for 5 seconds					
7. Keep brush in mouth for 1 minute					
8. Keep brush in mouth for 2 minutes					
9. Brush inside/outside front teeth					
10. Brush inside/outside back teeth					
11. Brush chewing surfaces of teeth					
12. Rinse and spit					
13. Put toothbrush/toothpaste away					

Oral Hygiene Skill Survery • page 2

Name _____ Caregiver Name _____ Start Date _____

Client Behavior	*Dates*	*Comments and Behavior*
STEPS		
Flossing		
1. Pull out 18 inches of floss		
2. Cut off floss		
3. Wrap floss around middle fingers of each hand		
4. Place both fingers on floss		
5. Hold inch section taut		
6. Slide floss in see-saw motion between teeth to gumline		
7. Wrap floss "C shape" around tooth		
8. Move floss up and down		
9. Lift floss over gum, do other tooth end		
Total		

Scoring Key

0 = Step could not be completed
1 = Caretaker completes step for individual
2 = Need to prompt to complete step
3 = Can complete step independently

Comments:

Appendix 7-C

Instructions for the
Oral Health Care Plan

The Oral Health Care Plan can be used to record plans for the individual you are assisting. A new Oral Health Care Plan should be written whenever there is a change in what oral health support is needed by the individual. For some individuals who are learning new skills very quickly, a new Oral Health Care Plan would need to be written more often than for other individuals.

Remember: *The most important thing that you, the DSP, can do is to consistently participate in the oral hygiene sessions.*

Watch for changes in scores on the Oral Hygiene Skill Survey to help the planning team decide when a new Oral Health Care Plan is needed.

Fill out the Oral Health Care Plan as follows:

Fill out the name of the individual you are assisting and the date. Then make an entry in each section.

- **Assessment:** Summarize the individual's physical and behavioral problems with oral hygiene.
- **Physical Skills and Aids:** Summarize the skills the individual is currently learning. Indicate any special aids being used and the schedule for using disclosing coloring tablets.
- **Partial Participation:** Indicate the best position for performing oral hygiene procedures and what techniques or special aids are being used. Describe the part of the procedures performed by the caregiver.
- **Structuring the Environment:** Put down the time of day for teaching. Note things needed to structure the environment for success. How will the oral hygiene session be organized physically, and who will do what?
- **Involving the Individual:** What choices can be offered? When can the individual stop the session?
- **Reinforcers:** List the first one to be used. Note additional reinforcers.
- **Steps to Be Reinforced:** When the first step is performed successfully for a few days, stop reinforcement for the first step, and offer it for good tries or success on the second step.
- **Other Prevention Actions:** It is very important to note needed disease prevention actions, use of fluoride, fluoride varnish, xylitol, and protective rinses, any dietary factors and the schedule for professional visits.

Remember: *Make the Oral Health Care Plan a part of the overall daily health plan for the individual you are assisting. Keep it updated and use it as a tool to communicate with the planning team and all caregivers.*

Oral Health Care Plan (sample)

Name: John Caregiver Name: Bill Start Date: 10-29-03

Assessments

a. Physical problems with oral hygiene: Weak hand grip, difficulty holding mouth open

b. Behavioral problems with oral hygiene: Just starting to like tooth brushing

Physical Skills and Aids

a. Skills being learned: Use brush in mouth for two minutes

b. Special aids: ☒ adapted toothbrush ☐ adapted floss holder ☐ electric toothbrush

c. Schedule for using disclosing tablets: Every week

Plan for **Partial Participation** (☐ not needed – person is independent)

a. Best position for assisting with oral hygiene: ☒ couch ☐ bean-bag chair ☐ other:

b. Techniques and/or aids used by caregivers: ☒ mouth prop ☐ floss holder

c. What part does caregiver perform: Brush tongue surface of back teeth

Plan for **Structuring the Environment**

a. Oral hygiene time and place: 6:30 every night after dinner

b. Are infection control procedures being used: Yes

c. Who will work with the individual: A.M. Sam P.M. Bill

Plan for **Engaging the Client**

a. Choices being offered: After dinner or before 8:30 p.m. TV show

b. Limits the client can set: Can decide not to do oral hygiene one day per week

Plan for **Reinforcers**

a. What reinforcers are being used currently (e.g. music, book, TV): Uninterrupted TV Thursday p.m., weekend trip to the park, verbal praise

Continued ▶

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Oral Health Care Plan • page 2 (sample)

Name: *John* Caregiver Name: *Bill* Start Date: *10-29-03*

Plan for **Shaping**

a. What steps are being taught: *Brush for 2 more minutes, get inside of lower teeth*

b. What level of prompts is currently being used?

☐ Physical (hand-over-hand) ☐ Physical (touch) ☐ Pointing ☒ Verbal

Other Prevention Actions

a. Xylitol: ☐ 5 minute exposure 3 x / day. Form being used: _____

b. Fluoride varnish: ☐ Applied 2 x / year. Next time: Applied 3 times in 1 week 1 x/ year.

Next time: _____

c. Fluoride rinses: ☐ Person rinses and empties mouth ☐ Caregiver uses swab technique

d. High concentration fluoride toothpaste or gel: ☐ How and when to apply

e. Chlorhexidine: ☐ Person rinses and empties mouth ☐ Caregiver uses swab technique

f. Diet: ☒ Decrease exposure to sugar and starches: ☐ How: *Reduce drinking sodas at night*

Professional visits and recommendations

a. Last dental cleaning appointment: Date: *8-14-03* Next appointment date: *2-1-04*

b. Next dental check-up or treatment appointment: *2-1-04*

Oral Health Care Plan

Name: _____ Caregiver Name: _____ Start Date: _____

Assessments

a. Physical problems with oral hygiene: _____

b. Behavioral problems with oral hygiene: _____

Physical Skills and Aids

a. Skills being learned: _____

b. Special aids: ☐ adapted toothbrush ☐ adapted floss holder ☐ electric toothbrush

c. Schedule for using disclosing tablets: _____

Plan for **Partial Participation** (☐ not needed – person is independent)

a. Best position for assisting with oral hygiene: ☐ couch ☐ bean-bag chair ☐ other:

b. Techniques and/or aids used by caregivers: ☐ mouth prop ☐ floss holder

c. What part does caregiver perform: _____

Plan for **Structuring the Environment**

a. Oral hygiene time and place: _____

b. Are infection control procedures being used: _____

c. Who will work with the individual: A.M. _____ P.M. _____

Plan for **Engaging the Client**

a. Choices being offered: _____

b. Limits the client can set: _____

Plan for **Reinforcers**

a. What reinforcers are being used currently (e.g. music, book, TV): _____

_____

Continued ▶

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Oral Health Care Plan • page 2

Name: _____ Caregiver Name: _____ Start Date: _____

Plan for **Shaping**

a. What steps are being taught: _____

b. What level of prompts is currently being used?

☐ Physical (hand-over-hand) ☐ Physical (touch) ☐ Pointing ☐ Verbal

Other Prevention Actions

a. Xylitol: ☐ 5 minute exposure 3 x / day. Form being used: _____

b. Fluoride varnish: ☐ Applied 2 x / year. Next time: Applied 3 times in 1 week 1 x/ year.

Next time: _____

c. Fluoride rinses: ☐ Person rinses and empties mouth ☐ Caregiver uses swab technique

d. High concentration fluoride toothpaste or gel: ☐ How and when to apply

e. Chlorhexidine: ☐ Person rinses and empties mouth ☐ Caregiver uses swab technique

f. Diet: ☐ Decrease exposure to sugar and starches: ☐ How: _____

_____

Professional visits and recommendations

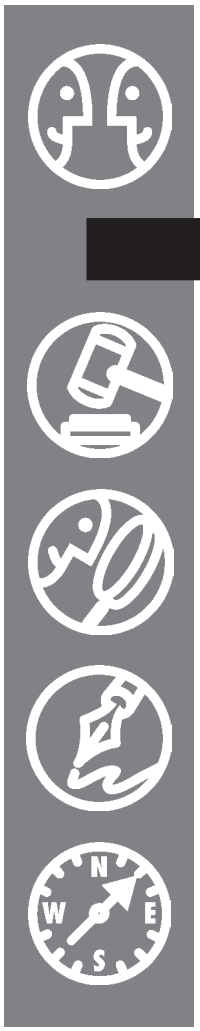
a. Last dental cleaning appointment: Date: _____ Next appointment date: _____

b. Next dental check-up or treatment appointment: _____

Appendix 7-D

Steps to Prevent Infection During Oral Hygiene Procedures

1. Set out dental supplies:
   - Toothbrush.
   - Paper tissues.
   - Two cups of water.
   - Disposable latex gloves.
   - Safety glasses for helper (from hardware store).
   - Toothpaste, if used.
   - Mouth prop, if used.
   - Floss and floss holder.
   - Disclosing tablets, if used.
   - Any prescription medication or mouth rinses.
   - Timer.
   - Oral Hygiene Skill Survey.
   - Oral Health Care Plan.
2. Review the last level of skill and the current plan for the individual.
3. Everyone (the individual and the DSP) should wash his or her hands with soap and water.
4. The helper should put on the protective glasses and a pair of latex gloves.
5. Begin tooth brushing and flossing. The helper should use the steps listed in the Oral Health Care Plan to assist the individual to have clean teeth, healthy gums, and maximum independence.
6. Once the gloves have touched a toothbrush, toothpaste, floss, floss holder, or individual's mouth, the gloves can go in only two places:
   - In that individual's mouth.
   - In the trashcan.
7. Offer one cup to the individual to rinse. Then wipe the mouth. Throw the tissue and cup in the trashcan. Swish the toothbrush in the other cup of water and discard the cup in the trashcan.
8. Return the supplies to the container.
9. The helper then removes the gloves by the pinching method and throws them in the trashcan.
10. Put the container and other supplies away.
11. Everyone (the individual and the DSP) should then wash his or her hands with soap and water.



Student Resource Guide

8. Signs & Symptoms of Illness or Injury

Student Resource Guide: SESSION 8

Signs and Symtpoms of Illness or Injury

OUTCOMES

When you finish this session, you will be able to:

- Identify changes that may be signs and symptoms of illness or injury.
- Know when to call 911 or the doctor or to provide treatment at home.
- Make a 911 call and provide necessary information.
- Report signs and symptoms to a doctor correctly.
- Document changes that may be signs and symptoms of illness or injury and your response.
- Describe how to take an individual's vital signs including pulse and temperature.
- Recognize the signs and symptoms of skin breakdown, constipation, overexposure to sun and heat, and choking.
- Identify ways to prevent skin breakdown, constipation, overexposure to sun and heat, and choking.
- Describe different types of seizures.
- Describe how to provide First Aid for a person having a seizure.
- Identify health problems related to aging.

KEY WORDS

Medical Emergency: An unexpected illness or injury calling for immediate attention to address a threat to an individual's life or safety.

Routine Treatment: Applying simple First Aid or following doctor's orders in response to signs of injury or illness.

Seizure: An abnormal electrical discharge in the brain.

Signs and Symptoms: Evidence of a disease, illness, or injury as observed by the DSP or reported by the individual.

Urgent Call to Doctor: An urgent call to the individual's doctor to report potentially serious signs or symptoms of illness or injury.

Recognizing Changes—the DSP as Detective

A detective is someone who looks for clues or needed facts to help solve a mystery. The DSP acts like a detective when looking for signs and symptoms of illness, uncovering clues, and making decisions about what to do next. In this session we will talk about how to use the DSP's tools of observation and communication to do good detective work when looking for changes that may be signs and symptoms of illness or injury and what to do when you see a change.

Early identification of changes in an individual's daily routines, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life. As a DSP, you have many opportunities throughout the day to identify changes that may be signs and symptom of illness or injury.

Good detectives get to know as much as possible about the individual they are observing. You get to know a person by spending time with him or her and learning what is usual for that individual, such as his or her daily routines, behavior, way of communicating, appearance, general manner or mood, and physical health. If you don't know what is normal for an individual, you won't know when something has changed.

You also need to know an individual's health history. This will help you to recognize a change in his or her physical health and to decide what to do. You will know if the change is something that has happened before and what was done, and you will have some strong clues as to what you need to do next.

Observation and Communication

To identify changes and gather information that will help you decide what you should do, you will use your tools of observation and communication.

Observation means using all of your senses: sight, hearing, touch, and smell. You may see a physical change, such as a tear-streaked face, redness or swelling of the skin, or cloudy urine. You may hear labored or noisy breathing, crying, moaning, coughing, or screaming. You may feel hot, moist, or cold skin. You may smell an unusual or unpleasant odor coming from the individual's mouth, body, or body fluids.

Communication includes both asking questions of and listening to the individual and others. A good detective asks a lot of questions. For example, if an individual tells you that her stomach hurts, you might ask, "When did it start hurting?" or "Can you show me where it hurts?" If you see an individual holding her stomach, grimacing, and crying, you might ask the individual, "Does your stomach hurt?"

If the individual is unable to use words to tell you, your detective skills—observation, listening, and questioning—become even more important. The individual in this example is holding her stomach, grimacing, and crying. These behaviors provide good clues that something is wrong. A good listener "hears" both words and other ways of communicating, including behavior.

You may also want to ask others. Talking to other staff at the change of shift or at the individual's day program, reading the documentation kept at your facility, such as the facility log, individual logs, or medication records, are all good ways of collecting information.

It may be challenging to detect a change. Many individuals with developmental disabilities have difficulty communicating with others. Some may "tell" you that they are in pain by crying, withdrawing, pointing, or screaming, while others may say, "I hurt," or "My stomach hurts." The clues may not always be so obvious and easy to detect. The individuals you support rely on you to be a good detective and to identify changes that may be the signs and symptoms of an illness or injury and to ensure that they receive appropriate treatment.

Learning More About Changes

So now you know that you identify changes by using your observation (see, hear, feel, and smell) and communication (listen and question) skills. Let's learn some more about the types of changes you may observe or learn about. Remember, changes may be in an individual's daily routine, behavior, way of communicating, appearance, general manner or mood, and physical health. The following are some examples of change that you may learn about in each of these areas and some questions that may help you.

Daily routine: an individual who usually goes to church on Sunday refuses to get out of bed; gets up at a different time; sleeps more or less; eats more or less; changes food preferences (starts eating salty foods); changes grooming habits (likes to brush his teeth but one day refuses to brush his teeth).

- You may want to ask, "Is the individual behaving differently than yesterday?" "Is the individual having new toileting accidents or trouble feeding or dressing himself?" "Is the individual refusing to eat his favorite foods?" "Is the individual having difficulty sleeping?"

ACTIVITY

The Good DSP Detective

Directions: Get into groups of no more than four. Think about a time that you had to use your detective skills to figure out why there was a sudden change in an individual you support. Tell your group about that incident and include:

- What was the change that you noticed?
- How did you identify it?

Share an example with the class.

Behavior: an individual who is usually calm starts hitting and kicking; appears more or less active than usual.

- You may want to ask , "Does the individual appear more or less active than usual?" "Is the individual acting aggressively to himself or to others?"

Ways of communicating: an individual who usually talks a lot stops talking; speech becomes garbled or unclear.

- You may ask, "Has the individual's ability to talk or communicate changed?"

Appearance: an individual who is usually very neat in appearance goes to work with uncombed hair, in a dirty, wrinkled shirt; changes in color or appearance (a sudden redness on the hands or an ashy tone and clammy feel to the skin); any changes in weight, up or down.

- You may ask, "Does it seem like the individual has lost interest in things?" "Is the individual taking less care in his or her dress?"

General manner or mood: Someone who is usually very talkative and friendly becomes quiet and sullen; an individual who usually spends her free time watching TV with others suddenly withdraws to her room and wants to be alone.

- You may ask, "Has the individual's mood changed?" "Does the individual want to be alone all the time?"

Physical Health

Changes in physical health are often identified by changes involving a particular part of the body. Some are changes you may observe, and others are changes an individual may tell you. For example, you may observe that an individual is pulling his ear or an individual may tell you that his ear hurts.

- You may want to ask, "Is there any apparent change to the individual's skin, eyes, ears, nose, or any other part of the body?"

Some physical changes to pay attention to include:

- **Skin:** Red, cut, swelling, rash.
- **Eyes:** Redness, yellow or green drainage, swelling of the eyelid, excessive tearing, or the individual reporting eyes burning and/or pain.
- **Ears:** Pulling at ear, ringing in the ears, redness, fever, diminished hearing, drainage from the ear canal, the individual reporting dizziness or pain.
- **Nose:** Runny discharge (clear, cloudy, colored), rubbing nose.
- **Mouth and throat:** Refusing to eat, redness, white patches at the back of the throat, hoarse voice, fever or skin rash, toothache, facial or gum swelling, gum bleeding, fever, individual reporting pain when swallowing.
- **Muscles and bones:** Inability to move a leg or an arm that the individual could previously move, stiffness, limited range of motion, individual reporting pain in the arms, legs, back.
- **Breathing (lungs):** Chest pain, cough, phlegm (mucous), shortness of breath or wheezing, fever, rash, stiff neck, headache, chills, nasal congestion, individual reporting pain in nose or teeth, dizziness.
- **Heart and blood vessels:** Numb or cold hands or feet, swelling of ankles, chest pain, shortness of breath.
- **Abdomen, bowel, and bladder (stomach, intestines, liver, gallbladder, pancreas, urinary tract):** Constant or frequent abdominal pain; bloating; vomiting; loose stools or diarrhea; constipation; blood in vomit or stools;

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fever; fruity smelling breath; difficult, painful and/or burning urination; changes in urine color (clear to cloudy or light to dark yellow); fruity smelling urine; nausea; pain on one or both sides of the mid-back; chills.

- **Women's health:** Vaginal discharge, itching, unusual odor, burning, changes in menses,such as change in frequency, length, and flow.
- **Men's health:** Discharge from penis, pain, itching, redness, burning.

To review, a change is anything that is different about an individual's daily routine, behavior, way of communicating, appearance, general manner or mood, and physical health. In order to recognize a change, you must first know the individual and what is "normal" for that individual. You identify changes by using your observation and communication skills. The individuals you support rely upon you to identify changes and to respond to those changes appropriately.

Assessing What to Do When You Learn About a Change

Many, if not most changes in an individual's daily routine, behavior, way of communicating, appearance, manner or mood, and/or physical health, require the DSP to take action. The following information will help you decide the appropriate action in each situation.

After you have identified a change, you must assess whether the change is a potential sign or symptom of illness or injury. Making the right decision involves taking everything you know and applying common-sense judgment. Knowledge of the person and his or her health history, including current medications and doctor's orders, are essential.

You should immediately recognize several changes as a sign or symptom of illness or injury. These signs and symptoms will require different levels of response, including:

Levels of Emergency Response:

- **911 Call:** Medical emergencies that require immediate medical attention.
- **Urgent Call to Doctor:** Potentially serious signs or symptoms that require an urgent report to the individual's doctor.
- **Routine Treatment:** Signs or symptoms that are addressed by simple First Aid or written doctor's orders.

911 Call

A 911 call involves medical emergencies that require immediate medical attention.

If you think you need to call 911, *do it*! Don't call someone to ask if you should. If you have any question in your mind, make the call. Timeliness in recognizing signs and symptoms that require emergency medical treatment can be the difference between life and death.

Always call 911 if an individual:

- Has bleeding that can't be controlled.
- Is or becomes unconscious (not related to a seizure).
- Has no pulse.
- Has trouble breathing or is breathing in a strange way.
- Has chest pain or pressure.
- Has severe injuries such as broken bones as a result of an accident.
- Is choking (not breathing and not coughing).
- Has injuries to the head, neck, or back.
- Has gone into shock.
- Has a seizure lasting five minutes or has continuous seizures.
- Has suffered electrical shock.
- Is drowning or near drowning.
- Experiences paralysis, numbness, confusion.
- Suffers severe burns (burns that cover more than one part of the body or on head, neck, hands, feet, or genitals).

If an individual appears to have been poisoned, first call the Poison Control Center at 1-800-8-POISON (1-800-876-4766) to get advice and then call 911.

When you call 911, tell them:

- Who you are
- Where you are
- What has happened
- When it happened

Stay on the phone until the dispatcher tells you to hang up.

While waiting for emergency medical personnel, stay calm and reassure the individual, stay with the him or her, and do necessary first-aid and/or CPR. If possible, send another person to watch for the ambulance to quickly guide the emergency personnel to the scene. When the emergency personnel arrive, provide them with additional information including current medications, allergies, insurance information, and the name and phone number of the individual's primary doctor. It is a good idea to also call the primary doctor as soon as you can.

Urgent Call to Doctor

An **urgent call to a doctor** is prompted by potentially serious signs or symptoms that require a timely report to the individual's doctor.

Some signs and symptoms indicate a need for urgent medical care. In these situations, the DSP should call the individual's doctor and report the signs and symptoms so that the doctor can assess the person's condition and determine the appropriate course of action. While the person's life may not be immediately threatened, the signs and symptoms listed below are serious, and the DSP must report them to the individual's doctor as soon as they are identified. The following are examples of changes that may be signs and symptoms of illness or injury and that require an urgent call to the doctor:

- Rapid change in behavior or an increase in challenging behavior such as aggression or self-injurious behavior.
- Sleeping most of the day; unusual difficulty in arousing; unusual fatigue.
- Scratching or holding one or both ears.
- Holding abdomen.
- Dramatic change in facial expression or demeanor.
- Evidence of pain or discomfort that is not easily explained.
- New or sudden onset of incontinence.
- Onset of fever of 101 degrees or higher.
- Diarrhea or vomiting lasting more than four hours.
- Rash lasting several days or getting worse.

- Increase in seizure activity.
- Onset of limping, inability to walk, or difficulty in movement.
- Severe sore throat/difficulty swallowing.
- Infection at injury site.
- Swelling.

Always report these changes to the doctor as soon as possible. *When in doubt, call the doctor.* When you call the doctor, stay on the phone until you get assistance. If you think the doctor did not understand how serious the situation is, or if it gets worse, call 911. Your actions can save a life.

When you call the doctor, tell him or her:

- What symptoms the individual has reported to you.
- What signs you have observed.
- What signs others have observed.
- When the change first began or was noticed.
- Any recent history of similar signs and symptoms
- Current medications.
- Known allergies.

ACTIVITY

Who Do I Call?

Directions: Using the following scenario, decide whom you would call and what you would say.

You are in the kitchen cooking lunch. You have your back to Margaret. Margaret says that she is going into the family room to watch TV. You hear her fall and start to scream. You immediately run to her side. You find her lying on the floor in the family room, clutching her leg, and screaming. Margaret is unable to get up from the floor.

- **Who would you call:** _____
- **Who you are:** _____
- **Where you are:** _____
- **What has happened:** _____
- **When it happened:** _____

Routine Treatment

Signs or symptoms that may be addressed with simple First Aid or for which there are written doctor's orders can be treated in the home. For example, a DSP may provide minor First Aid in the home for a small scratch on the finger. Some symptoms reported by the individual, such as a headache or swelling of the ankles, may be treated in the home if there are written doctor's orders that specify what to do. The DSP must be familiar with the individual, his or her health history, medications, and any written doctors' orders before deciding what to do.

ACTIVITY

What Would You Do?

For each sign or symptom listed in the left column, decide if you should respond by calling 911, placing an urgent call to the doctor, or providing routine treatment at home. Check the appropriate box on the right columns.

	Your Response		
Sign or Symptom	**911**	**Urgent Doctor Call**	**Routine Treatment**
Onset of fever of 101 degrees or higher	☐	☐	☐
New or sudden onset of incontinence	☐	☐	☐
Rash lasting several days or getting worse	☐	☐	☐
Bleeding that can't be controlled	☐	☐	☐
Severe sore throat/difficulty swallowing	☐	☐	☐
Infection at injury site	☐	☐	☐
Sleeping most of the day; unusual difficulty in arousing; unusual fatigue	☐	☐	☐
Scratching/holding one or both ears	☐	☐	☐
Holding abdomen	☐	☐	☐
Diarrhea or vomiting lasting more than four hours	☐	☐	☐
A seizure lasting five minutes or continuous seizures	☐	☐	☐
Paralysis, numbness, confusion	☐	☐	☐
Onset of limping, inability to walk, or difficulty in movement	☐	☐	☐
Mosquito bite	☐	☐	☐
Trouble breathing or is breathing in a strange way	☐	☐	☐
Visible swelling with doctor's order to elevate the leg	☐	☐	☐
Minor cut	☐	☐	☐
Is or becomes unconscious not related to a seizure	☐	☐	☐
No pulse	☐	☐	☐
Any evidence of pain or discomfort	☐	☐	☐
Chest pain or pressure	☐	☐	☐
Severe injuries as a result of an accident, such as broken bones	☐	☐	☐
Choking (not breathing and not coughing)	☐	☐	☐
Injuries to the head, neck, or back	☐	☐	☐
Has gone into shock	☐	☐	☐

Measuring Vital Signs

In your role as a detective, you may be called upon to take an individual's vital signs. The four vital signs are the individual's temperature, pulse, respiration, and blood pressure. Temperature and pulse are vital signs that you will most commonly use as a DSP.

Temperature

Temperature is the amount of heat in the body. Normal temperature is 98.6 degrees F. Anything within a degree either side (97.6 to 99.6) is considered normal.

There are various methods of taking a person's temperature. The most common is to use a digital thermometer. Digital thermometers are easy to read and hard to break.

To take an individual's temperature using a digital thermometer:

- Use a plastic slip to cover the thermometer.
- Press the button to set the thermometer.
- Place the thermometer under the tongue; have individual close mouth (breathing through the nose), for several minutes.
- Take the thermometer out of the individual's mouth to read when the temperature indicator lights.

If the individual is unable to keep the thermometer under his tongue, you may take his temperature under the armpit (with tip of the thermometer against dry skin and held in place by the arm), waiting five minutes (not four). Exercise raises an individual's temperature, so temperature should be taken at rest.

Do not use an oral thermometer for an individual who has a history of seizures, breathes through his or her mouth, has just had oral surgery, or is unconscious.

Pulse

Arteries carry blood from the heart to all parts of the body. A pulse is the beat of the heart felt at an artery as a wave of blood passes through the artery. You can feel a pulse every time the heart beats. The easiest and most common place to take a pulse (beats per minute) is on the inside of the thumb side of the wrist, using the first two fingers pressed against the skin. Count the number of beats over a 15-second interval and multiply by four. Repeat the process to check for consistency. Don't use your thumb because you could end up "reading" your own heart beats. A normal pulse will be about 70 beats per minute. Anything from 50 to 90 is within normal range for an adult.

Reading a pulse:

- Inside thumb side of wrist (easiest).
- Use first two fingers pressed against the skin (not the thumb).
- Count the number of beats over a 15-second period and multiply by four.

Respiration

Respiration is the act of breathing air into the lungs and out of the lungs. When counting respiration, pay close attention not only to the breathing rate, but also to wheezing, other sounds, and ease or difficulty breathing.

Respiration (breaths in and out) is best counted without telling the individual what you are doing. If the individual knows you are counting her breath, it may

change how she breathes. Count the rise or the fall of the chest for one minute. One respiration is an inhale and an exhale. In individuals above the age of 7, a normal respiration rate will be 12 to 24 breaths per minute.

Blood Pressure

Blood pressure is the amount of force the blood exerts when it is pushing against the walls of an artery. Blood pressure for adults 18 years of age and older falls in the following categories:

Normal: Below 120/80

High-normal: 120–139/80–89—pre-hypertension (high blood pressure)

High: 140/90 or higher—hypertension*

*Source: American Heart Association, Inc., 2002.

Normal blood pressure for children is lower.

The first number is the systolic measure, where the device that measures pressure by constricting the arm (or leg) first lets blood course through the vessels.

The lower number is the diastolic measure that records pressure when the blood is no longer heard. High blood pressure (hypertension*)* is often called a "silent killer" because symptoms of any kind are rare and such pressure, if persistent, can harden arteries and result in serious heart problems.

Blood pressure is affected by time of day (low at night; peak about eight hours after awakening); emotions (stress increases blood pressure); weight (obesity typically increases blood pressure); activity level; excess sodium (salt) intake; excess alcohol consumption; and use of certain drugs, including birth control pills, steroids, decongestants, and anti-inflammatory medications.

If high blood pressure is suspected or has been diagnosed, the doctor may ask the DSP to take consistent readings under the same conditions over a period of time. Blood pressure should be measured with the same device, at the same time of day, on the same arm (or leg), and with the individual in the same position (for example, sitting up). Mark down anything that might have affected the blood pressure, such as exercise (for example, the individual came in 10 minutes after riding a bike). In these situations, the DSP will follow the doctors instructions for taking blood pressure and documenting blood pressure readings.

Reporting and Documenting Changes

Regardless of what action you, as the DSP take, you must report (tell it) and document(write about it) in some way.

- Medical emergencies must be (1) documented in the individual's record and (2) submitted in a a special incident report that must be made to both the regional center and Community Care Licensing and other protective services agencies as required.
- Any call to the doctor must be documented in the individual's record and may require a special incident report.
- Any treatment provided in accordance with a written doctor's order or simple First Aid must also be documented in the individual's record.

Sometimes the correct response is simply to document the change that you have identified. This is important as over time, you and other DSPs may identify a pattern or trend and provide valuable information in the diagnosing of a health problem. For example, through continuous documentation of your observations, you may discover that an individual is losing interest in activities, which may be a sign or symptom of illness or injury. Many changes occur slowly over time and will only be identified if you and other DSPs consistently document and share observations.

You may be reporting changes (or signs and symptoms) to a number of different people, including a doctor, dentist, regional center service coordinator, behavior specialist, and your administrator. All of these contacts must be documented. Also, remember that signs and symptoms may be an indication of possible abuse or neglect that you are mandated to report to the appropriate protective service agency.

Always report and document changes as soon as possible. Some types of documentation, such as special incident reporting, have regulatory and statutory timelines that must be followed. For example, special incidents must be reported by phone to the regional center within 24 hours and in writing within 48 hours.

Here are some guidelines to add to your DSP documentation toolbox and to use when reporting and documenting changes that may be signs or symptoms of illness or injury:

- Write down what the individual said or did to communicate the change. For example, Bill said, "My stomach hurts," or "Fred walked up to me and pointed to his stomach, frowning and moaning."
- Do not try to make a diagnosis. The DSP is not a health care professional. Describe identified changes only.
- Do not document your personal opinion; for example, "Bill said his arm hurt, but I don't think there is anything really wrong."
- Be specific when reporting and documenting observed changes. For example, "I heard Jane screaming. She was sitting on the couch in the living room. The screaming lasted for about two minutes."
- When reporting and documenting answers to questions, report and document both the question and the response. For example, "Bill told me 'my stomach hurts.' I asked him, 'how long has it hurt?' Bill said, 'Since breakfast, and it really hurts bad.'" In the case where an individual does not verbally respond, the DSP should report and document the individual's response; for example, "I heard Jane screaming. When I asked Jane, 'What's wrong?' she put her hands on her head and began rocking."

ACTIVITY

Signs and Symptoms

Directions: Read the following scenario and answer the questions.

John, 57, complained of chest pain to Tom, the DSP on shift. Tom advised him to "take it easy." To be safe, Tom observed him more closely than usual throughout the morning. He also looked at John's record and saw he had a history of obesity and high cholesterol. He had been to the doctor three times in the last six months for "aches and pains," and no problems were found.

After John had eaten only part of his lunch, he again complained of pain and pressure in his chest. John went to watch TV in the living room. Tom went with him to make sure he was okay. After about 15 minutes, Tom observed that John was pale, sweating, and short of breath.

What are John's signs and symptoms?

What should Tom do next?

In this scenario, did Tom do the right thing?

Managing Chronic Health Care Conditions

In this section you will learn guidelines for supporting people with certain chronic health conditions. Since this curriculum is designed for *all* DSPs, it is impossible to review proper care and management guidelines for all the chronic health conditions that DSPs will encounter. DSPs are encouraged to talk to their administrator, the individual's doctor, and the service coordinator and review health records to learn how to provide the best possible support to individuals with any chronic health conditions. The regional center nurse may also be helpful and should have health care guidelines called *protocols* for most chronic health conditions requiring specialized care. Each individual is unique, and care plans can be very different for individuals with the same chronic health condition.

Diabetes

Our bodies convert the food we eat into fuel (glucose). Insulin is a hormone produced by the pancreas (an organ behind the stomach) that controls the amount of glucose in the blood. Diabetes occurs when:

- The pancreas does not produce any insulin (Type I diabetes), or
- The pancreas produces very little insulin (Type II diabetes).

Diabetes is a chronic disease with no cure. People with diabetes need to manage their disease to stay healthy.

Type I diabetes, or insulin dependent diabetes, usually occurs in childhood or adolescence but can develop at any age. People with Type I diabetes must inject insulin every day. There is no known way to prevent Type I diabetes.

Type II diabetes, or non-insulin dependent diabetes, is more common among adults, especially those who are overweight and over age 40. Over 17 million Americans have Type II diabetes. People with Type II diabetes can often control their blood sugar through weight control, regular exercise, and a sensible diet. Some may need insulin injections or oral medication to lower blood sugar.

How to Prevent Type II Diabetes

- Regular daily exercise.
- Maintaining a healthy body weight.

Who Is at Risk

- People who are overweight.
- People over age 40.
- People with a family history of diabetes.
- African-Americans, Hispanics, or Native Americans.

The symptoms of diabetes are often mild and frequently ignored. The DSP should observe the individual carefully and report these symptoms to the doctor. Diabetes can be diagnosed with a simple blood glucose test. Common symptoms of diabetes are:

- Increased thirst
- Frequent urination
- Increased appetite
- Unexplained weight loss or gain
- Fatigue
- Skin infections
- Slow-healing wounds
- Recurrent vaginitis
- Blurred vision

- ▶ Tingling or numbness of the hands or feet
- ▶ Itching of the skin

Get urgent care if an individual with diabetes:

- ▶ Loses consciousness.
- ▶ If signs of high blood sugar develop that include:
  - Frequent urination
  - Intense thirst
  - Dim vision
  - Rapid breathing
  - Fruity smelling breath
- ▶ If signs of low blood sugar continue after the person has eaten something containing sugar that include:
  - Fatigue, weakness, nausea
  - Hunger
  - Double or blurred vision
  - Pounding heart
  - Confusion, irritability, appearance of drunkenness

Epilepsy or Seizure Disorders

Of the nearly 190,000 people currently being served by regional centers, 24 percent are identified as having epilepsy.

A **seizure** is an abnormal electrical discharge in the brain. Seizures were once classified as "petit mal" and "grand mal." Today, the classification has two major categories, partial and generalized. This refers to origin in the brain. If a seizure begins locally in the brain, it is partial. If it encompasses the entire brain, it is generalized. Knowing general types of seizures is important to the neurologist in finding the right medication to prescribe.

Status Epilepticus stemming from either a partial or generalized seizure is potentially life threatening. It is defined as either repetitive tonic-clonic convulsions (without recovery) or a single, prolonged seizure. Brain damage can occur after about 20 minutes.

When a seizure occurs, observe the event carefully and document what occurred, including how long the person was unconscious (if loss of consciousness occurred). The DSP's documentation of a seizure can be vitally important to the individual's doctor, especially if there is something new. Details are helpful in making a proper diagnosis that, in turn, is related to the intervention (for example, a particular medication or class of medications).

If it is the individual's first (known) seizure, the DSP should place an urgent call to the doctor. If a siezure lasts for five minutes or more, call 911. Also call the physician who may want to examine spinal fluid to rule out infection or do other tests. If a person has a history of seizures, consult with the neurologist. The doctor may want to prescribe an "as needed" medication for repetitive seizuring on a given day or ongoing medication for seizure control. The doctor also may give specific directions to call 911 after some specific number of minutes (say 5, 10, 15, or 20), depending on the individual.

Top 10 First Aid Rules for Seizures

1. Keep calm! The individual is usually not suffering or in danger.
2. Protect the individual from injury. Prevention is the number one priority!
3. Loosen tight clothing. Do not restrain movements.
4. Turn the individual on his side with his face turned gently sideways or slightly down.
5. Do not put anything into the individual's mouth.
6. Do not give the individual anything to drink.
7. Reassure the individual.
8. Stand by until consciousness returns and confusion abates.
9. Allow a rest period (10–30 minutes for most people).
10. Document the seizure in the individual's log.

ACTIVITY

Understand Seizures and Seizure First Aid

Directions: Answer the following questions about the information in the video.

1. When a seizure occurs, what is happening inside the individual's brain?

2. To assist an individual having a tonic-clonic (that is, "grand mal") seizure, what should you do? Not do? Why?

3. To assist an individual having a partial seizure that doesn't generalize, what should you do? Not do? Why?

4. Under what circumstances is it appropriate to seek medical care right away?

High-Risk Health Problems

Individuals with developmental disabilities have a higher risk of serious health problems. They may be prone to skin breakdown, constipation, choking, sun and heat-related illness, and the early onset of age-related health conditions due to specific developmental disabilities or the treatment of certain conditions. DSPs need to know what preventive actions to take and how to identify changes that may be signs and symptoms of these conditions.

Skin Breakdown

Of the nearly 190,000 people currently being served by regional centers, 17 percent are identified as using wheelchairs or needing assistance to walk. Skin breakdown is a serious and constant concern for individuals who use wheelchairs and/or do not change positions. Pressure sores are skin breakdown over bony spots such as tailbone and hips.

Who Is at Risk for Skin Breakdown?

Individuals who use wheelchairs and/or people with mobility challenges.

How to Prevent Skin Breakdown

- Frequent movement and/or changing positions.
- Keeping the skin dry and clean.

What to Do If Skin Breakdown Occurs or Is Expected

Make sure the individual is examined by a doctor immediately.

Athlete's foot (*tinea pedia*) and jock itch (*tinea cruris*) are very common fungal infections that can cause skin breakdown. Like bacteria, fungi grow best in warm, moist areas of the skin, such as between the toes or in the groin. Fungus problems can be prevented by thorough drying off, wearing sandals or shoes that "breathe," wearing cotton underclothes and socks, and using talcum powder. DSPs should assist individuals to clean and dry both areas.

Some skin problems are very serious. Others are uncomfortable and passing. Some skin problems can be prevented or at least minimized through diet, proper clothing, and other actions. Some skin problems may be spread by contact, so remember to use hand washing and other infection control techniques. Always seek advice and treatment from the individual's doctor when new problems arise or the existing problem continues.

Constipation

Untreated constipation can lead to serious consequences including the need for surgical removal of the impacted fecal matter, rupture of the bowel, and even death.

Individuals who are at a higher risk for constipation:

- Have mobility challenges, such as using wheelchairs.
- Get very little regular exercise.

- Drink small amounts of fluids.
- Don't eat enough fiber in their diet.
- Take certain medications.

Preventing Constipation

- Eat a healthy diet with lots of fiber (fruits, vegetables, and whole grains).
- Exercise regularly.
- Drink plenty of fluids, especially water (eight glasses per day).

Each individual has a pattern of bowel movements that is "normal" for that him or her. Once the normal pattern of bowel movements is established, the DSP should look for any indication of a change. When an individual is not able to tell you that he had a bowel movement, or the doctor or other health care professional has determined that the individual is at risk for problems in this area, the individual program plan plan for that individual may include keeping a record of bowel movements.

Changes that are often signs and symptoms of constipation are:

- A change in the normal pattern of bowel movements (smaller amounts of stool, watery stool or diarrhea, unusual accidents).
- Loss of appetite.
- Increase in sleepiness and fussiness.
- Abdominal bloating.
- Persistent abdominal pain.
- Change in behavior.

Constipation can have serious consequences. If you identify any of these changes, call the individual's doctor to seek medical assistance.

Risks from Exposure to Sun and Heat

Overexposure to sun and heat can cause many problems—anything from mild sunburn to fatal sunstroke. Individuals are at risk of heat-related illness starting at temperatures as low as 80 degrees, depending upon length of exposure and level of physically activity.

Community Care Licensing requires all homes to maintain a comfortable temperature between 68 and 85 degrees at all times. In areas that are extremely hot, the maximum temperature must be 30 degrees less than the outside temperature. [Referenced Title 22, 80088.]

Preventing Sun- and Heat-Related Illnesses

It is the DSP's responsibility to protect each individual from sunburn, heat cramps, heat exhaustion, and heat stroke.

Individuals Who Are at Higher Risk

In general, children, the elderly, and individuals with developmental disabilities are at the greatest risk for sunburn and heat-related illness. Increased risk is also associated with taking certain medications and having certain characteristics, including but not limited to:

- Antihistamines used in cold and allergy medications.
- Antibiotics (sulfa drugs, tetracyclines).
- Antidepressants.
- Antipsychotics.
- Cardiovascular drugs.
- Oral medications for diabetes.
- Non-steroidal, anti-inflammatory drugs used to control pain and inflammation.
- Anti-dandruff shampoos.
- Fair hair or skin.

Preventing Sunburn and Heat-Related Illness

To prevent sunburn, use sunscreen with an SPF of 15 or more. Individuals with fair hair or skin who burn easily should use a sunscreen with SPF 30. Apply sunscreen to all exposed skin surfaces 20 minutes prior to going out in the sun. Reapply throughout the day and after the skin comes in contact with water. Use of sunscreen should be documented in the individual's record.

When temperatures rise:

- Wear a hat with a wide brim and lightweight and light colored clothing or use an umbrella.
- Wear long-sleeved, light cotton clothing.
- Drink 8 to 10 glasses of water a day. Drink even more if you are working or exercising in hot weather. Avoid caffeinated or alcoholic beverages.
- Take it easy! Limit physical activity during the hottest parts of the day.
- Stay inside if possible.
- If you must be outdoors for long periods of time, stay in a shady spot or bring a sunshade with you.
- For individuals with impaired movement, avoid temperatures above 95 degrees if at all possible.
- In the event of a power outage, consider going to a cool building or air conditioned car.

Never leave a child, an individual with a disability, an elderly person, or an animal in a car on a hot day. In as little as 10 minutes, the car can become a fatal furnace.

Sunburn is caused by exposure to the sun's ultraviolet rays. An individual can burn within 15 minutes any day of the year in California. Sunburns can occur even on an overcast day. People of color can also burn very easily. The degree to which someone burns or "tans" depends on the intensity of the sun's rays and the person's unique response to the exposure. Typical symptoms of sunburn are redness and pain in the skin. In severe cases there is also swelling, blisters, fever, and headaches.

In addition to sunburn, individuals with frequent exposure to the sun's ultraviolet rays have a high risk of developing skin cancer. Skin cancer is the most common form of cancer in the United States.

Treatment Tips: Have the individual drink lots of water. Aloe vera gel and certain other topical OTC moisturizers help reduce the pain. Contact the doctor immediately if severe blistering occurs, the individual feels very ill, or the individual's temperature is 102 degrees or more.

Heat cramps are painful muscle spasms usually in the legs or abdomen. The individual usually experiences heavy perspiration or sweating.

Treatment Tips: Have the individual move to a cooler place and rest in a comfortable position. Give him a glass of cool water every 15 minutes, but don't let him drink too quickly. Remove or loosen tight clothing and apply cool wet cloths. Do not give salt tablets. Call a doctor if the symptoms persist more than two hours.

Heat exhaustion causes an individual to be weak and sweat heavily. At the same time the skin is cold, pale, and clammy. The individual's pulse is weak and shallow. Fatigue, confusion, nausea, fainting, and vomiting may also occur.

Treatment Tips: Call 911 or go to the Emergency Room if:

- The individual's skin is dry even under the armpits and bright red or flushed.
- Body temperature reaches 102 degrees.
- The individual is delirious, disoriented, or unconscious.

Otherwise, get the individual to a cooler place and in a comfortable position. Give half a glass of cool water every 15 minutes but don't let the individual drink too quickly. Remove or loosen tight clothing and apply cool wet cloths, or sponge the body in a bath with cool water.

Heat stroke, also known as sunstroke, occurs when the individual's temperature control system has stopped producing sweat, which cools the body. Signs and symptoms of heat stroke are a high body temperature (102 and above), hot dry skin, and a strong rapid pulse. The individual may become unconscious.

Treatment Tips: Call 911 immediately. Move the individual to a cooler place and quickly cool the body by wrapping it in a wet sheet and fanning it. Put ice packs on the individual's ankles, wrists, and armpits to cool the large blood vessels. Keep the individual lying down and check his or her breathing.

Choking

Choking is a blockage of the airway that prevents an individual from breathing. Choking will result in death unless the airway is cleared immediately. Choking is a frequent safety hazard for individuals with developmental disabilities.

Individuals Who Are at Higher Risk

Many individuals with developmental disabilities experience choking episodes secondary to chronic health conditions. Cerebral palsy, which is often associated with difficulties in chewing and swallowing, is the most common. These individuals need close observation to help avoid choking incidents. Individuals with other conditions may have trouble with foods of different textures. Individuals taking certain medications may have dry mouth, which makes it harder to swallow. Be aware of individuals who eat or drink too fast. Individuals should be reminded not to talk or laugh with food in their mouths or to eat lying down. Individuals who frequently put too much food in their mouths may need to be provided with smaller amounts of food.

It is especially important to closely monitor individuals who take food from others. These individuals often put too much food in their mouth to avoid being caught.

Common Causes of Choking

- Trying to swallow large portions of poorly chewed food.
- Eating while talking excitedly or laughing.
- Eating too fast.
- Eating and walking, playing, or running with food or objects in the mouth.
- Eating certain foods like hot dogs, whole grapes, and hard candies.
- Taking medications that decrease alertness and muscle tone or cause dry mouth.
- Poor oral motor skills.
- Difficulty swallowing.
- Eating foreign objects.
- Vomiting.
- Aspiration (inhaling vomit, saliva, food, or a foreign object).

Signs of Choking

- Clutching the throat with one or both hands.
- Inability to speak, cough forcefully, or breathe.
- Turning blue in the face.
- High-pitched wheeze.

Treatment Tips: **It is strongly recommended that every DSP take a Cardio Pulmonary Resuscitation (CPR) class to learn the Heimlich maneuver, the typical procedure used to clear the airway when choking occurs. Classes are widely available. Check with your local Red Cross or Fire Department. By doing so, you may save a life.**

If someone is choking, immediately apply quick, upward abdominal thrusts (Heimlich maneuver). This will usually dislodge the object stuck in the person's windpipe. If the individual is in a wheelchair, get them out of the wheelchair to perform the Heimlich maneuver.

Health Problems Associated with Aging

Aging is the normal process of time-related changes that occur throughout life. Many individuals with developmental disabilities experience age-related changes earlier than the general population. This is particularly true for individuals with cerebral palsy, Down Syndrome and metabolic diseases and some individuals who have a mental illness in addition to a developmental disability. It is the responsibility of the DSP to identify changes that may indicate an early onset of an age-related health condition and to report these changes to the individual's doctor. Early detection permits early treatment that often adds to the individual's length and quality of life.

Signs and Symptoms of Age-Related Health Conditions

Again, DSPs should use their tools of observation and communication to identify changes in:

- Daily routines: Inability to perform self-care activities previously performed may indicate a memory loss.
- Behavior: Confusion, weak, unsteady, or tired.
- Communication: Ability to respond or initiate communication changes.
- Appearance: Sudden or progressive weight gain or loss.
- General manner or mood: Mood change, loss of interest in daily activities.

Physical Health Changes of Aging

Skin: Dry, flaky, bruises or tears easily, abnormal hardness, or visible lump on body.

Eyes: Dry eyes, squinting, or holding things close to the face may be a sign of vision loss.

Ears: Seemingly not paying attention, such as not responding to questions, may be a sign of a hearing loss.

Throat and mouth: Difficulty swallowing, choking or coughing with meals, cracked or loose teeth, trouble chewing, or mouth sores may be a sign of decreased oral health.

Muscles and bones: Loss of motor coordination; slowness of movement; unsteady gait; falling; curving of back; inability to stand up straight; pain without visible injury, especially in joints,

Breathing (lungs): Frequent colds, slow recovery from illness,

Heart and blood vessels: Numb or cold hands or feet, swelling of ankles, chest pain, shortness of breath.

Abdomen, bowel, and bladder (stomach, intestines, liver, gallbladder, pancreas, urinary tract): Constipation, "gassy" or black stools, bleeding, frequent or difficult urination, or many trips to the bathroom.

In summary, the DSP learns about changes through observation (using all of his or her senses) and communication with the individual and others. Knowing how to identify changes in an individual's daily routines, behavior, ways of communicating, appearance, general manner or mood, and physical health and knowing what to do when you have identified a change enables you to protect individual health and safety and may save a life.

PRACTICE AND SHARE

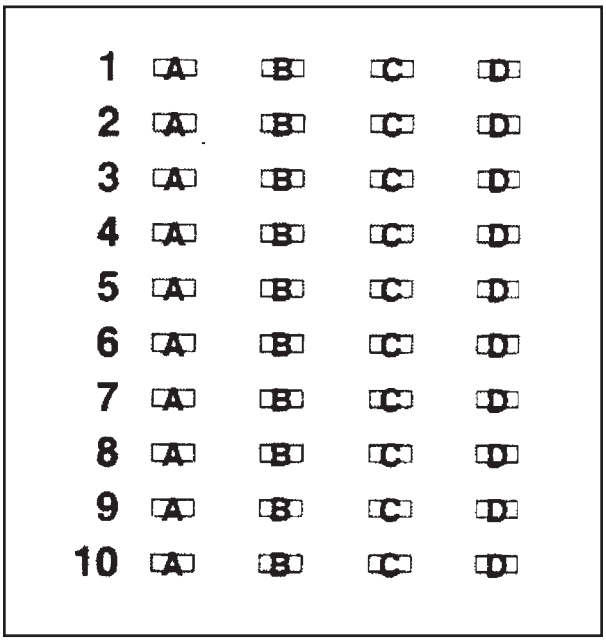
In the home where you work, look around and answer the following questions:

1. Where are emergency phone numbers kept?
2. Is the poison control phone number available? If not, share the number with your administrator.
3. What other emergency information is available?

If you support an individual with a seizure disorder, answer the following:

1. What, if any, seizure medication is the individual taking? What are the side effects?
2. Does the individual have an emergency alert bracelet or necklace?

Signs and Symptoms of Illness



1. **An example of a change in a person's daily routine is:**
   A) Sleeping much later than usual.
   B) Suddenly becoming aggressive to other people.
   C) Speaking much less than is normal for that person.
   D) Unexplained changes in the appearance of the skin.

2. **When calling 911, you should always:**
   A) Get the name of the dispatcher for the facility's records.
   B) End the call within two minutes to free the line for another caller.
   C) Tell the dispatcher your opinion about what is happening.
   D) Tell the dispatcher who and where you are.

3. **Which one of the following would be least likely to require an urgent call to the person's doctor?:**
   A) Infection at the site of an injury.
   B) An increase in seizure activity.
   C) Fever of 101 degrees.
   D) Headache.

4. **Headaches and swelling of ankles are examples of changes in a person's health condition that may be treated in the home if::**
   A) There are written orders from a doctor prescribing the home treatment.
   B) An experienced DSP has decided the health change is not serious.
   C) The person does not want the doctor to know about the situation.
   D) If is not possible to reach the 911 dispatcher.

5. **The easiest and most common place to take a pulse is:**
   A) In the quietest room available inside the facility,
   B) Between 50 and 90 beats per minute.
   C) On the inside of the thumb side of the person's wrist.
   D) Under the armpit, unless the person can shut their mouth completely.

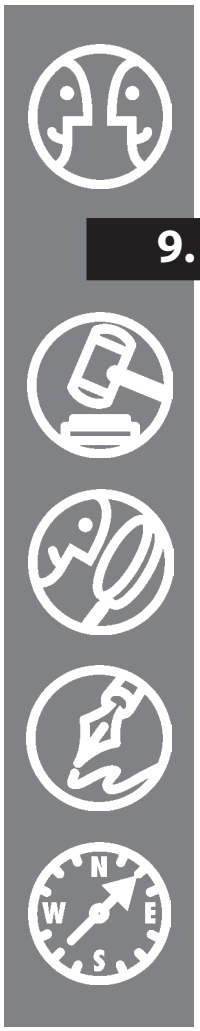
6. **Of the following, the single most important reason for documenting changes in a person's health is:**
   A) To practice your skills as a DSP at every opportunity.
   B) To make it easier to be aware of health changes that occur slowly over time.
   C) To document that the person's health has improved as a result of the good care being given in the home.
   D) To accurately report abuse to a protective service agency.

7. **Athlete's Foot and Jock Itch are common fungal infections of the skin that can often be prevented by:**
   A) Keeping body parts covered as a barrier against air-borne fungus.
   B) Removal of the toes and groin especially in individuals with chronic infections.
   C) Keeping body parts dry and well-aired.
   D) Limiting unsupervised contact between individuals and athletes.

8. **To assist a person who is having a tonic-clonic seizure, you should:**
   A) Place the person on their side, if possible, so that he or she does not choke.
   B) Strongly restrain the person's movements, to prevent injury.
   C) Place a clean cloth in the mouth to prevent the tongue from being bitten.
   D) Gently, but firmly, keep the person's back to the floor or other flat surface.

9. **Which one of the following may be a symptom of sunburn?:**
   A) Overcast days.
   B) Redness and pain in the skin.
   C) A temperature between 68 and 85 degrees.
   D) Sitting in a car for more than 15 minutes on a hot day.

10. **The DSP looks out for early signs of conditions associated with old age mainly because:**
   A) Persons with developmental disabilities tend to get older as time passes.
   B) No person should get old unless it is a preference noted in their IPP.
   C) Early treatment may add quality and length to the person's life.
   D) Conditions that develop later in old age cannot be treated successfully.



Student Resource Guide

9. Risk Management: Environmental Safety

Student Resource Guide: SESSION 9

Risk Management: Environmental Safety

OUTCOMES

When you finish this session, you will be able to:

- Describe how to create and maintain a safe home environment to prevent falls, poisonings, and other injuries.
- Describe how to prevent and respond to a fire.
- Describe how to prevent drowning.
- Identify the principles of body mechanics that prevent self-injury to the back.
- Identify the rules for safely transporting an individual in a wheelchair.
- Describe exercises that help prevent back problems.
- Describe what constitutes a medical emergency.
- Describe what constitutes an environmental emergency.
- Describe how to be prepared for, and respond to, external disasters.

KEY WORDS

Environmental Emergency: A disaster; for example, a flood, fire, earthquake, or chemical spill.

First Aid: Emergency care given to an ill or injured person before medical help arrives.

Hazard: A potentially dangerous situation.

Lifting: To raise an individual or an object.

Safety: The practice of creating and maintaining a hazard free environment by always doing things in a correct and careful manner.

Safety Is About Awareness and Prevention

Safety means creating and then maintaining a hazard free environment by always doing things in a correct and careful manner. But accidents happen, don't they? Is there some way to prevent them? In the first risk management session, we discussed a number of ways to minimize risk for the individuals we support. We spoke of assessing situations so we could anticipate problems before they occurred and brainstormed strategies to mitigate those problems. In fact, the first safety principle for Direct Support Professionals is *preventing serious incidents is the Number One Priority*.

As a DSP, you can prevent accidents and, if they do occur, manage them in a way that minimizes injury to both you and the individual. Following are some basic practices that reduce the risk of injury to individuals and staff. If children are present, additional practices and steps to prevent injury must be taken. See Appendix 9-A.

Practices that Reduce the Risk of Injury

- Being aware of what makes for a safe environment and creating and maintaining one.
- Knowing and practicing the principles of risk management.
- Locking medications and toxic substances.
- Having good lighting.
- Ensuring adequate room to move and eliminating tight spaces or pinch points.
- Eliminating any tripping hazards.
- Always practicing proper body mechanics when lifting.
- Using proper wheelchair handling.
- Sharing information about hazards.
- Knowing and practicing emergency contingency plans.
- Knowing First Aid.
- Knowing CPR.

Safety Around the House

Would it surprise you to know that 20,000 persons die each year in the United States from home accidents? In 1998 more than 10 million people were injured at home severely enough to warrant emergency room visits.

Many factors and events contribute to injuries in the home and community. Three major sources of injuries at home and in the community are poisonings, falls and fires. In 1999, fires were the third leading cause of injury-related deaths among children 1 to 9 years old and the fifth leading cause among people 65 and older. Poisonings are the second leading cause of accidental death in the home. Falls were the third leading cause of injury-related deaths among Americans of all ages and were the leading cause of injury-related deaths among people ages 65 and older.

DSPs can increase safety and reduce the likelihood of injury or death by:

- Creating and maintaining a safe environment.
- Doing things in a safe manner.
- Learning how to respond appropriately when injuries occur.

Poisoning

One of the most tragic and preventable causes of injury and death is accidental poisoning. A poison is a substance that causes injury or illness if it gets into the body.

There are four ways a poison can enter the body:

- Swallowing
- Breathing
- Touching
- Injecting

Combinations of certain substances can be poisonous, although if taken by themselves they might not cause harm. Not everyone reacts to poisons in the same way. A substance that is harmful to one may not always be harmful to another.

Preventing Poisonings

Many common household chemical products are poisonous and deserve special handling and labeling. All potentially poisonous products found in the home must be

1. Stored in their original containers.
2. Kept separate from food items.
3. Be inaccessible and locked up to prevent individuals from eating or drinking them or getting them on their skin or in their eyes.

ACTIVITY

Identifying Household Poisons

Directions: Read this list of common household products and put an "X" next to the ones that are in the home you work in. Next, identify additional products found in the home that may be poisonous. Consider how accessible they might be and what steps you might take to prevent an accidental poisoning. This will not be shared with the large group, so use this exercise as a strategy to make your home even safer!

Common Household Poisons

- ☐ *Alcohol*
- ☐ *Laundry detergent*
- ☐ *Moth balls*
- ☐ *Dishwasher detergent*
- ☐ *Nail polish and nail polish remover*
- ☐ *Drain cleaner*
- ☐ *Oven cleaner*
- ☐ *Drugs of any kind*
- ☐ *Glass cleaner*
- ☐ *Furniture polish*
- ☐ *Scouring pads*
- ☐ *Scouring powder/pads*
- ☐ *Toilet cleaner*
- ☐ *Weed killer*
- ☐ *Air freshener*
- ☐ *Insecticide*
- ☐ *Bleach*
- ☐ *Cigarettes and tobacco*
- ☐ *Cosmetics*
- ☐ *Glass cleaner*
- ☐ *Grease remover*
- ☐ *Any cleaning product*
- ☐ *Paint and paint thinner*
- ☐ *Any medications*

Additional products:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

ACTIVITY

Strategies for Minimizing the Risk Around the House

Directions: Read the scenario. In the "Risk" column, write down specific risks for Matthew regarding accidental poisoning. In the "Plans for Minimizing Risk" column, write down ideas for how to minimize the risk of poisoning.

Matthew is an 8-year-old boy with developmental disabilities. He lives in a small family home located just outside of Bakersfield. Matthew has been living there for the past two years. He is a curious, engaging young man who communicates in a range of ways, such as single words, sign language (approximately 15 signs), pointing, and using pictures. Matthew has recently started using a picture exchange communication system, and he is able to find familiar pictures in his book. Because Matthew has mild cerebral palsy, his gait is unsteady, and his balance is poor.

Matthew is able to undress independently and can do most of his own dressing. He needs reminders to use the bathroom and support to do most of his hygiene. Matthew makes some poor decisions regarding his personal safety; for example, he tends to put things into his mouth, and therefore staff needs to stay close to him in the community.

Jim has been working as a DSP for the past month. This is his first experience with individuals with disabilities. So far, he enjoys the job and has developed a nice relationship with Matthew. He also likes the administrator, April Young, as she has been very helpful.

Description of Risk*	Plans to Manage Risk

***Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.**

Be Prepared

Even when preventive steps are taken, an accidental poisoning may occur. If this happens, the DSP must get emergency medical assistance as quickly as possible. In emergency situations, the DSP who is prepared and who maintains control is the most helpful. We might believe that we know what we would do in an emergency, but it's just at this critical time that we realize we aren't prepared. We thought the poison control number was here by the phone. Who moved it? Are we supposed to make him vomit or not? Should we get him in the car and rush to the hospital?

In 1997, the California State Poison Control System was inaugurated. Everyone in California can use a common number. Your call will be automatically routed to the appropriate division able to respond. The first step in being prepared to handle an accidental poisoning is to post the Poison Control phone number—**1-800-876-4766 or 1-800-8-POISON**—next to the phone in a way to avoid its being moved.

Emergency Response to a Poisoning Incident

In the event of a poisoning, immediately call the Poison Control Center and:

- **Remain calm.**
- **Have someone stay with the individual.**
- **Report the source of the poisoning (brand name and label, if possible).**
- **Report the amount ingested (if you don't know, say so).**
- **Report age and weight of the person.**
- **Report elapsed time since the incident occurred**.

Poison Control Center: 1-800-8-POISON (1-800-876-4766)

In some cases, it will be recommended to give the individual Ipecac syrup to induce vomiting. This is a way of getting the poisonous substance out of the body quickly. However, it is not always recommended. With some poisons (for example, petroleum-based products or acids), inducing vomiting is not a good approach because of the potential damage to the esophagus, lungs, or mouth. Do not use it to induce vomiting unless Poison Control says to do so. If vomiting occurs, save what is thrown up.

Ipecac syrup should be kept on hand, but locked up. Check expiration dates and replace as needed since it loses its effectiveness with the passage of time.

In the event chemicals or other toxic substances have been splashed in the eyes, flush them gently with water.

ACTIVITY

Dealing with Poisoning or Drug Overdose

Directions: Pair up with another student and role-play calling the Poison Control Center. One person will perform the role of the DSP calling the Poison Control Center, and the other person will act as the Poison Control Center representative. There are four situations. Each student should make two of the calls.

Scenario #1.

DSP staff member: "One of our children was playing in the field beside our house and ate a mushroom that was growing there. He brought in a small piece of the stem, but I don't know how to identify poisonous from non-poisonous mushrooms. What should I do?"

Poison Control staff:

1. Where was the mushroom growing? On grass, near trees, on wood?
2. When did this happen?
3. How is the individual doing?
4. Does the individual have any medical conditions?
5. What is the name and age of the individual?
6. What is the name of the caller, the phone number, and zip code?
7. Do you have Ipecac syrup in the house?
8. How close is the nearest emergency room?

Scenario #2.

DSP staff member: "We just admitted a new resident to the home. We discovered that he had various strength Thorazine (chlorpromazine) in his clothes and in different boxes. Apparently, his roommate found at least one on the floor and ate it. The pills do look like M&Ms. The roommate fell asleep eating dinner. We roused him and tried to find out what color the pill was, but he is unsure. It was either brown or red. What should we do?"

Poison Control staff:

1. Is he awake? If not, can you wake him? Is he breathing okay?
2. How long ago did this happen?
3. Are you sure it was Thorazine?
4. Was there only one pill involved, or could he have eaten several?
5. How old is he?
6. How much does he weigh?
7. Does he have any medical conditions?
8. Is he taking any medications?

ACTIVITY

Continued from previous page

Scenario #3.

DSP staff member: "A man with a developmental disability who lives with me was doing the dishes, and he says that he ate some of the dishwasher detergent (granule form). What should I do?"

Poison Control staff:
1. Is the man having any symptoms?
2. Is this automatic dishwashing detergent?
3. Has he received any water or milk?
4. Are there any burns in his mouth, or is he having problems swallowing?
5. Does he have any medical conditions?

Scenario #4.

DSP staff member: "Sam was using Super Glue on his model airplane project. When he was brushing back his hair, he got a glob of the glue in his eye, or at least I think he did because his eye is closed. What should I do?"

Poison Control staff:
1. Is he complaining of any eye pain?
2. Have you tried to irrigate his eye under the kitchen faucet or under the shower?
3. Are the skin surfaces glued together or just the eyelashes?
4. Does he wear contact lenses?

Falls

All of us, at one time or another, have fallen. Sometimes we were tripped by another person, or we were just careless and not looking where we were going. Most of the time, it's only our pride that is injured, but too often, falls result in physical injuries. In fact, about 7,000 Americans die each year from falls at home. One of every three home accidents is a fall.

Falls commonly occur on flights of stairs, ladders, chairs and stools, roofs, and when getting in and out of bathtubs. Some falls are caused by individuals stepping on an unseen object such as marbles or a skateboard. Individuals of all ages fall out of bed or while getting out of bed. One of every four falls is on a level surface.

Falls are caused frequently by carelessness. Some people just trip. Others are in too much of a hurry, playing roughly, or don't see an object before they fall over it. Some falls are caused by health problems such as fainting, poor eyesight, hypertension, osteoporosis of the hip, or overmedication. Sometimes people fall when they are helping others in some way.

Here is the concern for DSPs. The individuals we support, because of their disabilities, medication, and at times, health problems, are at an increased risk of falling and of suffering injuries such as broken teeth, hips, legs, ankles, and arms. For example, individuals with epilepsy sometimes experience hard falls with resultant injuries during their sudden unexpected seizures. Similarly, poor coordination and muscle problems associated with cerebral palsy can cause someone to fall, especially when the individual has a wobbly or unsteady gait.

Preventing Falls

There are a number of ways a DSP can reduce the risk of falls in the home for both consumers and staff including:

- Identify individuals at risk for falling and document fall precautions in the IPP.
- Be sure individuals needing assistive devices (canes, walkers) use them and store them properly.
- Keep cords, wires, and hoses out of walkways.
- Make sure adequate staff are available when a person is physically lifted from one place to another, and make sure there is enough space.
- Provide hand rails and guard rails at all elevated walkways or stairs.
- Use safety adaptations in the shower, such as a rubber mat in the bathtub or shower stall, a shower bench when the individual is unsteady or not well coordinated, or grab bars in the bathtub or shower stall.
- Keep the floors dry and clutter free.
- Install night lights in bedrooms, halls, and bathrooms.
- Be sure nothing (clothes, toys, books) is left on stairways or on the floor.
- Use non-skid matting under floor rugs.
- Carpet stairs (rubber runner on stairs to basement).
- Replace worn out carpet and make sure it doesn't come loose.
- Use a ladder (or move one) rather than stretching to reach something.
- Use well-maintained ladders and always have another person close by.
- Provide good outdoor lighting on walks and driveways.
- Where it is icy, put sand or salt on porches and other walkways.

Emergency Response to a Fall Incident

Even with the best precautions, falls may occur. How well the DSP performs in providing immediate assistance, preventing additional injury, and obtaining medical assistance if necessary is what makes the difference in the result of a fall.

Once he or she becomes aware of the situation, the DSP needs to carefully and quickly assess the situation by *listening, observing, and questioning*:

- **Listen** to what the individual is telling you.
- **Observe** the position of his body and look for signs of bleeding, broken limbs, or breathing problems.
- **Ask** the individual what he or she is feeling.

The response of the DSP to an individual's fall depends on the circumstances of the fall, the person's ongoing health status, and what injury the person appears to have sustained.

If an individual appears to be seriously hurt, is bleeding badly, complains of sharp pain, appears to have a broken bone(s) such as an arm, leg, hip, or back, or appears to have a change of consciousness, **CALL 911 FOR ASSISTANCE. DO NOT MOVE THE INDIVIDUAL**.

Document all falling incidents in the individual's record and complete a Special Incident Report (SIR).

ACTIVITY

Identifying Fall Risks

Directions: Think about the home you work in. Are there unsafe conditions that could lead to falls? For example, are there:

- *Objects, items, or slippery surfaces in the home that could lead to falls?*
- *Unsafe practices by individuals that could lead to falls?*
- *Unsafe practices by staff that could lead to falls?*

In the "Descritption of Risk" column, write down specific unsafe conditions. Then think of possible actions that would eliminate or reduce the risks. In the "Plans to Manage Risk" column, write down ideas for minimizing the risk of falling.

Description of Risk*	Plans to Manage Risk

***Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.**

Fires

Fires are the third leading cause of accidental deaths in the home. They often result in serious injury and cause extensive property damage. One-third of deaths from fire (burning or smoke inhalation) occur between midnight and 4:00 a.m., when most people are sleeping.

Preventing the fire is the number one priority. Many fires are the result of neglect, indifference, carelessness (the most common cause of fire is careless smoking), or laziness, and we can do something about these things.

Preventing Fires

Residential sprinkler systems are the *best way* to provide life safety in a house fire. Such systems will suppress 9 out of 10 fires and provide a "window of opportunity" so that people have time to exit. Consider "rate of rise" smoke detectors in kitchens and garages, places more likely to have a fire where there is a sudden change of temperature with little smoke. Bedrooms and living rooms should have hard wired smoke detectors with battery back-up. Smoke detectors wired into an alarm system provide additional security. If the detectors are battery operated, they should be checked monthly, and batteries should be replaced at least yearly.

Fire prevention is a team activity. A number of things can be done to minimize fire hazards in the home.

- Check smoke detectors monthly, and replace batteries annually or as needed.
- Use canned smoke, not an open flame, to test smoke detectors.
- Place fire extinguishers in appropriate places, such as the kitchen.
- Train staff to use fire extinguishers.
- Have fire extinguishers serviced periodically.
- Teach everyone in the home what to do if a fire occurs; for example, safely exiting the home.
- Windows in bedrooms should not be more than 44 inches above the floor to allow for egress.
- Do not allow smoking in bed. Even better, do not allow smoking in the house.
- Do not leave matches or lighters around.
- Set all cigarettes, smoked inside or outside the home, in an ashtray.
- Dispose of cigarette butts in a tin can with sand. Be careful not to empty this can just after burying a cigarette butt in the sand.
- Clean ovens and fireplaces on a regular basis.
- Do not overload electrical circuits.
- Do not use extension cords running under rugs.
- Repair frayed or shredded electrical cords immediately.
- Use extreme care with space heaters. Be sure the circuit is sized to handle the heater.
- Do not let rubbish (especially paper, rags, and old clothes) accumulate under stairs, in the attic, or in the basement.
- Keep flammable liquids in tightly closed metal containers, away from heat sources.
- Store any rags used to wipe up oil or paint in a tightly closed metal containers, or submerge them in water and dispose of them quickly.

- Be sensitive to gas leaks. Call the gas company and get out of the house if you smell gas.
- Be careful with all electrical appliances and make sure they are in good working condition (hair curling iron, toaster, irons, or space heaters).
- Use proper wattage bulbs in lamps.

Responding to a Fire

Become acquainted with and use the prevention services of local fire departments. Disaster Plans should be checked out with fire department officials and revised according to recommendations made by these fire prevention experts.

What to Do If You Smell Smoke or Discover a Fire

Having a plan and practicing the plan is critical. A Disaster Plan should be simple. In an emergency, stay calm and take specific actions.

In case of fire:

- Ensure that the individuals in the home are safe by immediately helping them leave the home as fast as possible and go to the designated meeting place.
- Do not stop to get any belongings.
- Once out, STAY OUT. Never go back into a burning building for any reason. If someone is missing, tell the firefighters.
- Call 911 from a neighbor's house or cell phone.
- If there is smoke in the room, stay low or crawl to your exit.
- If you can't escape, put wet cloth or bath towels or fabric around doors to block off smoke, crawl to a window, and open it. Yell out the window for help and wave a sheet or cloth for attention. If there is a phone in the room, call for help.

Fire Drills, Preparation and Planning

Community care facilities are required to have fire drills regularly, and document the results. In preparation for drills, or in addition to drills, a lot of valuable teaching and learning is possible. Here are some things to teach individuals living in your home:

- Reacting to an alarm by exiting along a path that avoids the fire.
- Remaining calm and walking, crawling, or wheeling out of the house.
- Once outside the house, going to an agreed-upon meeting point, such as the edge of the street in front of the neighbor's house in order to be accounted for.

Homes Must Have Fire Escape Plans

Here are some things that belong in the plan:

- Floor plans, showing escape routes.
- A rendezvous point that is outside the home and away from danger.
- Specific roles and responsibilities of DSPs and residents.
- Location of multi-purpose, labeled "A-B-C" fire extinguishers.

An "A-B-C" fire extinguisher can be used on all types of fires: wood, cloth and paper fires; oil, gas and kerosene fires; and electrical fires as well. Other types of fire extinguishers work only on certain types of fires.

Fire extinguishers have a role if a fire is small and can be readily contained, but it is important for staff to follow fire escape plans. Practicing these plans should be a regular and frequent exercise for both staff and residents. Drills should be scheduled to cover various shifts, and some should be when individuals and staff are inconvenienced (in bed, taking a shower). The more practice individuals have, the more likely they will act responsibly and safely in the event of a real emergency.

A fire emergency is something none of us want to ever experience. By taking prevention seriously, we can avoid fires in most cases. Having a clear plan and practicing that plan frequently will offer more assurance that staff and residents will act responsibly and safely in an emergency.

Emergency Treatment for Burns

While staff is waiting for assistance, it might be necessary to provide some immediate treatment for burns. Minor burns (for example, sunburn or contact with hot objects) are treated by submerging the affected area in water and applying a dry dressing if necessary.

Second-degree burns—which are deeper and which often blister and appear to be wet—are treated by immersing in cold (not ice) water and blotting dry. You may apply sterile dressing and elevate the limbs, but avoid ointments.

Third-degree burns are those with complete loss of all layers of skin and a white, charred appearance. These are best left to medical emergency staff. In the meantime, leave clothing intact and watch for possible breathing complications. You might apply cold packs to face, hands, or feet for comfort, but do not immerse burned areas in ice water.

ACTIVITY

Identifying Fire Risks

Directions: Think about the home you work in. Are there unsafe conditions that could lead to fire? For example:

- *Are smoke detectors checked monthly?*
- *Are matches and lighters left out on counters?*
- *Do you know where the fire extinguishers are and how to use them?*
- *Are there piles of old clothes or newspapers in the home?*

In the "Description of Risk" column, write down specific unsafe conditions. Then think of possible actions that would eliminate or reduce the risks. In the "Plans to Manage Risk" column, write down ideas for how to minimize the risk of fire.

Description of Risk*	Plans to Manage Risk

***Remember to think about the individual's health, behavior, daily living skills, environment, and lifestyle choices.**

Drowning

Facts About Drowning

- Drowning is the second leading cause of unintentional injury-related death among children under the age of 15.
- Individuals can drown not only in natural bodies of water, but in bathtubs, swimming pools, and hot tubs.
- Drowning rates are three times higher in rural areas than urban areas.
- Alcohol use is involved in about 50 percent of adolescent deaths associated with water recreation.
- Males account for 92 percent of drowning deaths in the 15–19 year bracket.

Near drowning is the term used when a person survives for at least 24 hours following such an event. For each child who dies from drowning, approximately four children are hospitalized for near drowning. One-third of near drowning victims who are comatose upon admission to the hospital and survive suffer neurological impairment. Regional centers provide services to over 500 persons in California who have developmental disabilities caused by near drowning accidents.

Individuals with developmental disabilities are at increased risk for drowning because of the lack of water safety awareness. Individuals with epilepsy are at increased risk, and suffering a seizure in the water can be fatal.

Preventing Drowning

Community Care Licensing requires fences around swimming pools that are climb-resistant and at least four feet high. There must be locked gates and careful supervision of individuals in the water by someone trained and certified in water safety. Some additional precautions that prevent drowning include:

- Never leave a small child or adult with cognitive or physical challenges (spastic quadriplegia, seizures) in a bathtub, shower stall, hot tub, swimming pool, wading pool, irrigation ditch, or other body of water for any reason.
- Don't allow diving into water that is less than four feet deep.
- Don't allow rough play or running near a swimming pool.
- Do not leave water in containers, pails, or buckets.
- Keep electrical cords and devices away from water.
- Teach everyone water safety and, if possible, how to swim.
- Require all children and individuals who do not swim well to use an approved personal flotation device whenever riding on a boat or fishing and preferably while playing near a river, lake, or ocean.
- Avoid alcohol when swimming.

Helping with Transfers, Positioning, and Lifting

There are two reasons to become more skilled at transfers, positioning, and lifting. First, we do not want to injure the individual we are helping. Second, we do not want to injure ourselves. Assisting another person to move can put a great deal of strain on our bodies unless we practice the proper strategies. At some time during their lives, four out of five people experience back problems such as severe muscle spasms, strained back muscles, or a slipped disc. The DSP is no exception.

Amber is a young woman who uses a wheelchair. She is able to move the chair by herself, but requires assistance to transfer from her bed, another chair, or the toilet to her wheelchair. Direct Support Professionals who work in Amber's home have become used to lifting her into her chair. They do this on the average of six times a day, and she only weights about 95 pounds. While they know they should follow certain steps in assisting her, the DSPs are often in a hurry and take some short cuts. Phyllis, a DSP who has supported Amber for the past eight months, has recently begun to feel some pain in her lower back in the mornings. It seems that as she gets going, her back loosens up, so she's not that concerned about it. A couple of anti-inflammatory pills usually do the trick.

Lifting and Protecting One's Back

Unfortunately, Phyllis may be experiencing early signals that she is doing some damage to her back. Amber may not weigh much, but lifting 95 pounds in this way is putting a strain on Phyllis' back. How can Phyllis minimize back problems without leaving this job she absolutely loves?

Minimizing back problems calls for two things:

1. Using our bodies properly when lifting, pushing, or reaching.
2. Practicing exercises to strengthen our backs.

We can do a number of things when we have to lift, push, or reach for something, no matter how light the item is.

When lifting or moving an object:

- **Use wheel devices whenever possible.**
- **Push, don't pull, items such as a garbage container or a cart.**
- **Move to the item, rather than reach for it.**
- **Squat, rather than bend over, to reach down for something.**
- **Turn, rather than twist, to go in a different direction.**

  Twisting motions, especially with a heavy load, place considerable stress on the spine.
- **Keep the natural curve of the spine intact.**

  A commonly recognized problem is lifting loads from the floor. But overhead loads can also be hazardous. It is better to build platforms to store loads off the floor (above knee height) to eliminate bending over and to keep loads below shoulder.
- **Lift loads at about waist height.**

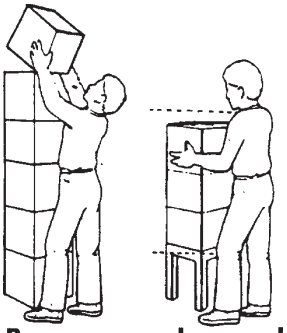
  Ideally, loads should be at about waist height when lifted. For example, ad-

justable height stands can be used to raise pallets of boxes up and down to the right height (and also to accommodate employees of varying heights). Reaching down into tubs and bins is a common source of back stress. Possible solutions include hydraulic tilters, spring-loaded bottoms, and drop-down or removable sides.

- **When possible elevate tubs and install wall hung toilets to provide toe space to improve lifting.**

Principles of Good Body Mechanics

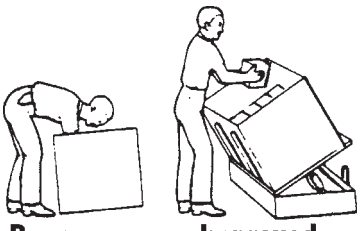
Keep the natural curve of the spine intact
A commonly recognized problem is lifting loads from the floor. But overhead loads can also be hazardous. It is better to build platforms to store loads off the floor (above knee height) to eliminate bending over, and to keep loads below shoulder height.



Adjustable-height "scissors lift"

Lift loads at about waist height
Ideally, loads should be at about waist height when lifted. For example, adjustable height stands can be used to raise pallets of boxes up and down to the right height (and also to accomodate employees of varying heights).

Reaching down into tubs and bins is a common source of back stress. Possible solutions include hydraulic tilters, springloaded bottoms, and drop-down or removable sides.



Eliminate twisting motions
Twisting motions, especially with a heavy load, place considerable stress on the spine. Improved layout is usually the best approach for eliminating this issue.

Helping Individuals with Abnormal Muscle Tone and Impaired Mobility

Some Specific Transfer and Positioning Guidelines

Individuals vary in size, muscle tone, and control of their bodies. They also have different needs with regard to help in moving about. Some people need help turning in bed. Some need help to sit up. Some need help in scooting forward or backward in a chair or bed. Some need help moving from the bed to a chair, from a chair to the toilet, from a chair to bed, or from a chair (or bed) to the floor. Some need help walking from one place to another without falling.

A plan, for each individual with whatever training is needed for the DSPs and individual, should be devised.

Sometimes, a single helper can assist someone.

Sometimes, two or more people may need to work together.

Sometimes, mechanical aids such as a Hoyer lift may be needed.

In any situation, when positioning and/or transferring someone, DSPs should attend to the following principles:

- **Take time to plan.**

  Insure there is enough room to do the lift. Make sure you have good footing and light.

- **Ask the individual how he or she wants to be assisted.**
- **Encourage as much participation as possible by the individual you are assisting.**
- **Use equipment (boards, sheets, lifts, and so forth) when possible.**
- **Team up with another person when a two-person lift is needed.**
- **Use good body mechanics (good technique).**

Exercises for Preventing Back Problems

As a DSP, using proper techniques for lifting and moving people and objects is critical to ensure the safety of the individual being assisted as well as to prevent injury to you. You may also be able to help yourself by doing exercises to strengthen your back.

Strengthening your entire body prevents future back problems and also improves your general health. Many exercises and sports strengthen your arms and legs, and special exercises to strengthen your abdominal muscles are also encouraged. Keeping your body flexible helps you to use proper body mechanics that protect your back.

Be sure to check with your physician or other health care professional before starting the exercises.

THESE EXERCISES ARE NOT RECOMMENDED FOR USE DURING AN ACUTE BACK PROBLEM OR SPASM. IF ANY EXERCISE CAUSES INCREASED OR CONTINUING BACK PAIN, STOP THE EXERCISE AND TRY SOMETHING ELSE. STOP ANY EXERCISE THAT CAUSES THE PAIN TO RADIATE AWAY FROM YOUR SPINE INTO YOUR BUTTOCKS OR LEGS, EITHER DURING OR AFTER THE EXERCISE.

You do not need to do every exercise. Stick with the ones that help you most. Start with 5 repetitions three to four times a day, and gradually increase to 10. Do all exercises slowly. The basic types of exercises that can help your back include flexion, extension, and stretching and strengthening.

Exercises for Preventing Back Problems (continued)

Basic Exercises

The following basic exercises fall into four groups:

- **Flexion.**
  Flexion exercises stretch the lower back muscles and strengthen the stomach muscles.
- **Extension.**
  Extension exercises strengthen your lower back muscles.
- **Warm up with movement and walking.**
- **Weight resistance training.**
  Weight resistance training improves muscle tone and strength.

Flexion Exercises

Curl-Ups

Curl-ups strengthen your abdominal muscles, which work with your back muscles to support your spine.

- Lie on your back with knees bent (60 degree angle) and feet flat on the floor, arms crossed on your chest. Do not hook your feet under anything.
- Slowly curl your head and shoulders a few inches up until your shoulder blades barely rise from the floor. Keep your lower back pressed to the floor. To avoid neck problems, remember to lift your shoulders and do not force your head up or forward. Hold for 5 to 10 seconds (do not hold your breath), and then curl down very slowly.

Pelvic Tilts

This exercise gently moves the spine and stretches the low back.

- Lie on your back with knees bent and feet flat on the floor.
- Slowly tighten your stomach muscles and press your low back against the floor. Hold for 10 seconds (do not hold your breath). Slowly relax.

Extension Exercises

Press-Ups

Begin and end every set of exercises with a few press-ups.

- Lie face down with hands at shoulders, palms flat on floor.
- Prop yourself up on your elbows, keeping lower half of body relaxed.
- If it's comfortable, press your chest forward.
- Keep hips pressed to the floor. Feel the stretch in your low back.
- Lower upper body to the floor. Repeat 3 to 10 times, slowly.

Backward Bend

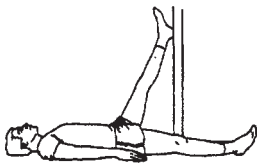
Practice the backward bend at least once a day and do it frequently when working in a bent forward position.

- Stand upright with your feet slightly apart. Back up to a counter top for greater support and stability.
- Place your hands in the small of your back and gently bend backward. Keep your knees straight (not locked) and bend only at the waist.
- Hold the backward stretch for one to two seconds.

Exercises for Preventing Back Problems (continued)

Stretching Exercises

Hamstring Stretch



This stretches the muscles in the back of your thigh that allow you to bend your legs while keeping a natural curve in your back.

- Lie on your back in a doorway with one leg through the doorway on the floor and the leg you want to stretch straight up with the heel resting on the wall next to the doorway.
- Keep the leg straight and slowly move your heel up the wall until you feel a gentle pull in the back of your thigh. Do not overstretch.
- Relax in that position for 30 seconds, then bend the knee to relieve the stretch. Repeat with the other leg.

Hip Flexor Stretch

This stretches the muscles in the front of your hip, which avoids "swayback" caused by tight hip muscles.

- Kneel on one knee with your other leg bent and foot in front of you. Keep a natural curve in your back.
- Slowly shift your weight onto your front foot, maintaining a natural curve in your back. Hold for 10 seconds. You should feel a stretch in the groin of the leg you are kneeling on. Repeat with the other leg.

Strengthening Exercises

Prone Buttocks Squeeze

This exercise strengthens the buttocks muscles, which support the back and aid in lifting with the legs.

- Lie flat on your stomach with your arms at your sides.
- Slowly tighten your buttocks muscles. Hold for 5 to 10 seconds (do not hold your breath). Slowly relax.
- You may need to place a small pillow under your stomach for comfort.

Safely Transporting an Individual in a Wheelchair

Some of us have become so used to seeing people using wheelchairs that we forget that there are things we need to consider in terms of safety and comfort. A wheelchair is an example of adaptive equipment that must be individualized for the individual using it. Our first consideration is to assist an individual to move and at the same time, to reduce the risk of injury when he or she uses the chair. We also need to remember to include the individual so he or she can be part of any social interaction. In schools, some teachers have created wheelchair safety classes for peers who are interested in pushing their friends in wheelchairs. Completing this class and gaining a wheelchair safety license helps to ensure that no one is injured and that peers are demonstrating respectful behavior.

As we prepare to assist an individual to use a wheelchair, here are some critical points to consider:

- **Self-mobilization**: Does this individual want your assistance? Can the individual move himself or herself? If yes, encourage him to transport himself as much as possible.
- **Individual sitting position**: Before starting check for the following:
  - Are the individual's hips all the way back in the wheelchair?
  - Does the seat belt need to be attached?
  - Are footrests in place, and are the individual's feet on the footrests?
  - Are the individual's hands on the armrests or in his or her lap, away from the wheels?
- **Brakes:** Are the brakes locked prior to assisting an individual into or out of a wheelchair?
- **Holding on**: Are you grasping both push handles on the wheelchair firmly?
- **Starting and stopping**: Are you starting and stopping slowly, taking corners slowly, and maintaining a steady pace while moving? This is to avoid jostling the individual or throwing him or her off balance.
- **Surface levels**: Are you alert for changes in surface levels; for example, doorjambs or the floor of an elevator? Hitting a half-inch rise at standard wheelchair speed can bend the front casters and pitch the individual forward.
- **Opening doors**: Are you opening doors by stopping the wheelchair, opening the door by hand and slowly bringing the wheelchair through? Never open doors by pushing with the front of the wheelchair. This can damage the wheelchair's footrests, the individual's feet, or the door. If the door does not stay open on its own, hold it with one hand or your backside. Do not let the door bang the side of the wheelchair.
- **Inclines and ramps**: Are you ensuring that the individual's weight is always pushing back toward you on inclines? The individual's weight should always be pushing back toward you on inclines and ramps. Going uphill means pushing the individual; to go downhill, turn the chair around and walk backwards. In this manner, the individual's weight will push back toward you.
- **Curbs:** Are you using the large wheels to roll over curbs?
  - **Up curbs**—Stop at the curb, raise the front casters by pressing down on the foot lever, roll the front casters onto the sidewalk, and roll the large wheels over the curb by lifting slightly on the push handles as you push forward.

– **Down curbs**—Always come down curbs facing backwards with the large wheels coming first. Maintain some upward pressure on the push handles as you pull the wheelchair toward you.

The above guidelines are from *The North Dakota Staff Training* manual, pp. 77–78), 1995

Medical Emergencies

A DSP is constantly making decisions, and one of the most serious decisions is to determine when medical attention is necessary.

> A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention.

Some emergencies call for an immediate response to protect life.

All emergencies call for a prompt response, either calling 911 or calling a Poison Control Center (1-800-8-POISON) and getting advice.

Emergency Action:

Calling for help is often the most important action a DSP can take to help the individual in need of aid.

ALWAYS Call 911 if the individual:

- Has bleeding that can't be controlled.
- Is or becomes unconscious not related to a seizure.
- Has no pulse.
- Has trouble breathing or is breathing in a strange way.
- Has chest pain or pressure.
- Has severe injuries such as broken bones as a result of an accident.
- Is choking (not breathing and not coughing).
- Has injuries to the head, neck, or back.
- Has gone into shock.
- Has a seizure lasting five minutes or continuous seizures.
- Suffers electrical shock.
- Is drowning or near drowning
- Has paralysis, numbness, confusion
- Suffers severe burns that cover more than one part of the body or on the head, neck, hands, feet, or genitals

If an individual appears to have been poisoned, first call the Poison Control Center at 1-800-8-POISON (1-800-876-4766).

Call 911 if any of the following circumstances apply:

- Fire or explosion.
- Downed electrical wires.
- Swiftly moving or rapidly rising water.
- Presence of poisonous gas.
- Vehicle collisions with injuries.
- Shooting.

When you call 911, tell them:

- Who you are.
- Where you are.
- What has happened.
- When it happened.

Stay on the phone until the dispatcher tells you to hang up.

What to Do Until Medical Help Arrives

You've done the right thing calling for help. Whenever you are concerned about an injury or medical condition, calling for assistance is the right thing to do. While you are waiting for assistance, there are some very important things you can do to give the individual the best possible chance to recover.

Until medical help arrives:

- **Stay calm** so that you can reassure the individual and not add to fear and concern, which in and of itself is understandable, but not helpful.
- **Stay with the person.**
- **Maintain airway**, if necessary by tilting the head back.
- **Control bleeding**, by application of pressure or use of a tourniquet if necessary.
- **Treat for shock** by having the person lie down and by loosening clothing, covering with a blanket, and seeking medical attention.
- **Have a current medical history ready** to give to the paramedics including, at a minimum:
  - Name, date of birth, current address, and phone number
  - Current medications
  - List of allergies
  - Insurance information (for example, Medi-Cal card)
  - Information about what happened and when
  - Physician's name and telephone number

It is a good idea to have all health information, including a copy of the individual's health history and consent-to treatment forms, in a separate folder, available for DSPs to give to emergency personnel.

First Aid

Immediate, life-saving techniques are learned and are taught in First Aid and CPR classes. First Aid is required by Community Care Licensing regulations. In addition to First Aid, CPR is a great skill to have. The Red Cross and other organizations offer these classes. Medical emergencies call for action. Not being able to breathe and/or having no pulse call for immediate action on the scene.

First Aid techniques include:

- Abdominal Thrusts
- Rescue Breathing
- Cardio-Pulmonary Resuscitation (CPR)

First Aid Supplies

Every community care facility (CCF) must have the following minimum supplies at a central location within the home:

- A current edition of a First Aid manual approved by the American Red Cross, the American Medical Association, or a state or federal health agency.
- Sterile first aid dressings.
- Bandages or rolled bandages.
- Adhesive tape.
- Scissors.
- Tweezers.
- Thermometer.
- Antiseptic solution.

It is important that every DSP knows where these supplies are in the home and how to use them.

Environmental Emergencies: Fire, Earthquake, and Flood

We can rarely predict environmental emergencies, but we can do our best to prepare for them. How DSPs react in an emergency depends upon their recognition of potential risks, their skill in following the emergency plan, and their ability to remain calm in the face of uncertainty.

Some environmental emergencies are internal, as when a fire occurs within the home. Others are external, as when an earthquake, flood, tornado, toxic spill, or other event outside the home interferes with power, water, food supplies, or other essential services.

Some external disasters trigger internal ones as well, as when a flood damages a home or an earthquake triggers a fire.

External disasters, which include floods, earthquakes, high winds, toxic spills and the like, typically disrupt travel, communications, and basic utilities such as gas, water, and electricity and put an intense strain on emergency services, including medical care.

To minimize the likelihood of an environmental emergency and to respond well, a DSP needs to follow the "4 Ps":

- **PREPARE** … have the right things available.
- **PLAN** … decide who will do what.
- **PRACTICE** … fire and disaster drills.
- **PERFORM** … the right action in an emergency.

Responding to Disasters

Once a disaster occurs, there are four questions that must be asked.

- Are there injuries that require First Aid and medical attention?
- Does the home have to be evacuated, or is it safe to occupy?
- Are there sources of food and water?
- Has the disaster interfered with public utilities, such as gas, electricity, and communications?

Disaster Preparation

Following the "4 Ps" helps one minimize the likelihood of an environmental emergency and respond to such an emergency well.

PREPARE

Every home needs to have critical supplies on hand because of the disruption environmental disasters create. In addition to fire extinguishers and smoke detectors that every home should have, each household needs a number of other items, including:

- First Aid kit and First Aid book.
- Adjustable wrench for turning off gas and water.
- A battery-powered radio, flashlight, and plenty of extra batteries.
- Bottled water sufficient for the number of members in the household (1 gallon per person per day).
- A one-week food supply of canned and dried foods for each household member.

  NOTE: These should be replaced regularly: water every six months and canned goods once a year. These containers should, of course, be dated.
- Non-electric can opener.
- Portable stove such as butane or charcoal.
- Matches (NOTE: Do not light if there is any smell of gas).
- Credit cards and cash.
- An extra set of keys.

- A current posted Disaster Plan, with information about relocation, Poison Control, and physician names and telephone numbers.

In addition, DSPs must have a number of items for each individual living in the home including:

- List of current medications being taken and prescribing physician.
- Currently prescribed medications on hand.
- Emergency information (for example, name, date of birth, home address, and phone number; name, address, and phone number of administrator; Medi-Cal or other medical insurance numbers; known allergies and food sensitivities; and name, address, and phone number of relatives or closest friends).
- Medi-Cal or other insurance card.
- Signed consent-to-treatment form, with phone number of the regional center or other placement agency.
- Other personal and health-related information in a readily accessible form.
- A change of clothing, rain gear, and sturdy shoes.
- Blankets or sleeping bag.
- Any needed adaptive equipment or assistive device (for example, wheelchair, extra pair of glasses).

PLAN

Community Care Licensing requires all facilities to have a Disaster Plan (see Appendix 9-B). DSPs should assist in creating and refining the home disaster preparedness plan. Participating in developing the plan makes it more likely that DSPs will understand the reason for actions they should take and may also result in identifying strategies for a more successful plan.

PRACTICE

Each DSP should know how to respond appropriately to an external disaster, and practice is the way this is accomplished. Knowing you need to turn off the gas is only useful if you know how to do this and have the tools to complete the task. DSPs should know how to:

- Turn off gas, water, and electricity.
- Provide first aid.
- Get individuals to the assistance they need.
- Communicate with other staff.

PERFORM

The nature of an external disaster will dictate how best to respond at the time. It is always advisable to stay calm. For example, in an earthquake, the best way to respond depends on where you are at the time. If you are inside a building, stay away from windows, stand in a doorway, or crouch under a sturdy desk or table. If you are outside, stand away from buildings, trees, and telephone and electrical lines. If you are in a car, drive away from underpasses or overpasses, stop in a safe area, and stay in the car.

After an earthquake, one should:

- Check for injuries and provide any needed first aid.
- Check for gas, water, electrical, or other breaks. Turn off utilities where danger exists (for example, if you smell gas, turn off gas near meter).
- Check for building damage (for example, around chimneys and foundations).
- Clean up dangerous spills (for example, glass or water).
- Turn on your radio and listen for instructions.
- Use the telephone only for emergencies.

ACTIVITY

Disaster Planning and Response

Directions: Using the disaster the teacher has given you, write down what you would do to Prepare, Plan, and Practice.

Prepare

What do you need to have on hand?

Plan

What steps will you take in the event of this disaster? (Be sure to be specific; for example, who will do what?)

Practice

Describe the plan for DSPs and consumers to practice steps.

PRACTICE AND SHARE

Review the Disaster Plan for the home where you work and do the following:

- Is the plan up to date? If not, tell your administrator.
- Locate the emergency exits.
- Does the home have an "A-B-C" fire extinguisher? Is it charged? If not, tell your administrator.

Risk Management: Environmental Safety

1	A	B	C	D
2	A	B	C	D
3	A	B	C	D
4	A	B	C	D
5	A	B	C	D
6	A	B	C	D
7	A	B	C	D
8	A	B	C	D
9	A	B	C	D
10	A	B	C	D

1. **The DSP's single most important safety principle is:**
   A) Women and children first.
   B) Prevention is the Number One priority.
   C) Never take deep breaths while under water.
   D) There is no such thing as an "accident."

2. **Which of the following does not help reduce the risk of accidental injury?**
   A) Practicing proper body mechanics when lifting.
   B) Eliminating tripping hazards.
   C) Respecting cultural differences.
   D) Having good lighting.

3. **All potentially poisonous products found in the home must be:**
   A) Taken with five glasses of water, or more.
   B) Thrown out in the trash as soon as discovered.
   C) Kept separate from food items.
   D) Placed in tightly closed containers labeled "Weed Killer."

4. **The best protection to take for protecting lives in a fire is to:**
   A) Carry as much fire insurance as possible.
   B) Escape through an open window of opportunity.
   C) Equip the residence with a sprinkler system.
   D) Hide in a tightly closed closet until the fire truck arrives.

5. **Which one of the following is helpful in preventing drowning deaths?**
   A) Never leave less than three young children alone in a pool.
   B) Never dive into a pool unless it is filled with water.
   C) Individuals who cannot swim should wear flotation devices.
   D) Keep electrical cords and equipment completely under the water.

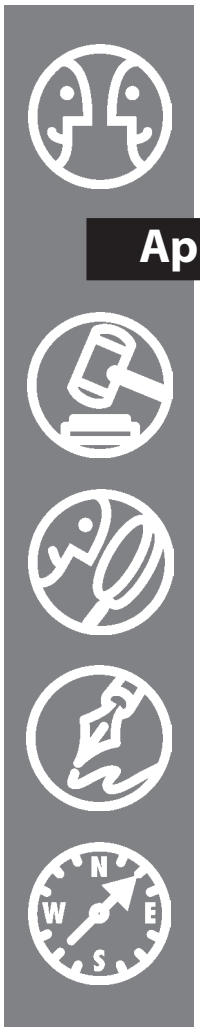
6. **Which one of the following is not a principle of good body mechanics?**
   A) Push items such as a garbage container or cart, instead of pulling them.
   B) Squat, rather than bend over to reach down for something.
   C) Twist to the right when lifting a heavy object.
   D) Move to an item rather than reach out for it.

7. **When moving an individual in a wheelchair along a ramp, the DSP should be positioned:**
   A) Along either side of the wheelchair, with one hand on the wheel and another hand grasping the upper arm of the individual.
   B) Between the top of the ramp and the wheelchair.
   C) Between the bottom of the ramp and the wheelchair.
   D) Either in front of, or behind, the wheelchair, depending on the steepness of the ramp.

8. **A pelvic tilt:**
   A) Requires immediate attention of a physician.
   B) Can be corrected by a backward bend.
   C) Involves tightening stomach muscles while lying on your back.
   D) Is the name of a technique used in lifting individuals into wheelchairs.

9. **A "medical emergency":**
   A) Is a serious accident that occurs away from the facility.
   B) Is an unexpected event requiring first aid, followed by prompt medical attention.
   C) Requires a triage nurse to determine what first aid is needed, when poison has been taken.
   D) Always requires immediate transportation to the nearest Emergency Room or Urgent Care Center.

10. **The "4 P's" of responding to an environmental emergency are:**
    A) Prepare, practice, perform, and prevail.
    B) Prepare, plan, propose, and prevent.
    C) Prepare, plan, practice, and perform.
    D) Prepare, propose, prevent, and perform.



Appendices

Appendix 9-A

Safety for Children

Safety for Infants

1. Never shake a baby!
2. Never leave an infant alone on a bed, changing table or other high object.
3. Always put crib rails up when stepping or turning a way from the infant.
4. Place a baby down to sleep on his or her back or on the side, with the lower arm forward to stop infant from rolling over.
5. Place a baby on a firm mattress and do not use fluffy blankets for comforters under the baby. Do not let a baby sleep on a waterbed, sheepskin, pillow, or other soft material.
6. Cover electrical outlets with childproof covers.
7. Make certain that wires and cords from lamps, appliances, etc. are not hanging where a child could easily pull them, causing something to fall.
8. Keep gates in front of steps and stairs.
9. Keep all medicine, household cleaners, and any other toxic substance out of the reach of children, in a locked cabinet.
10. Keep childproof latches on all drawers and cabinets to prevent an infant, toddler, or small child from opening.
11. Keep all plastic bags away from infants and small children.
12. Keep needles, safety pins, coins, beads and other small objects away from infants and small children.
13. Never give an infant or young child foods such as popcorn, peanuts, grapes raw vegetables, marshmallows, hot dogs or other items which may obstruct a child's airway.
14. Place hot coffee pot or other hot item in the center of the table. Do not place hot items on a table with a tablecloth, unless the child is supervised.
15. Never leave a child alone in a bathtub, or near other bodies of water, such as a fishpond or swimming pool. A child's small inflatable plastic pool can also be dangerous if the child is not supervised.
16. Use a sunscreen with an SPF of 15 or higher when taking an infant or child outdoors.
17. Always place an infant in a car seat, which has been properly installed. Place infant car seat in back seat.
18. Never leave a child alone near a lighted stove, fireplace, barbeque, burning candle or lamp.

Safety for Toddler and Preschooler

1. Keep all power and hand tools out of the reach of children.
2. If you have Venetian blinds with cords having loops at the end, cut the loop in order to avoid the child getting his or her neck caught in it.
3. Keep matches out of reach.
4. Always turn the handles of pots and pans towards the back of the stove.
5. Learn which plants are poisonous and keep young children away from them.
6. Be certain children are fastened in carriages and strollers.
7. Never leave a child alone in a carriage, stroller or shopping cart.
8. Never leave a child alone in the house or a parked car.
9. Children weighing up to 60 pounds or up to six years of age should ride in a car seat.
10. Never place a child in the front passenger seat with passenger side air bags.
11. Discard old refrigerators, freezers, or stoves or have the doors removed from them.
12. Never have firearms (loaded or unloaded) where a child can reach them.

Safety for School Age

Among school-aged children, motor vehicle accidents are the leading cause of death, followed by pedestrian injuries. A high percentage of non-fatal injuries are due to falls. Consideration for keeping school-aged children safe include:

1. Use seatbelts at all times in automobiles. See above section for placement of car seat or booster seat.
2. Use appropriate fitting helmets on all children riding bicycles.
3. Educate children about the danger of going into the street. Set boundaries. Use door alarms or other devices in home of children who may not understand and dart into the street.
4. Always have adult supervision when swimming.
5. Teach the child about appropriate interaction with strangers (getting into cars, answering doors, etc.)

Disaster Plan for Residential Care Facilities

Disaster Plan

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

EMERGENCY DISASTER PLAN FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY, COMMUNITY CARE FACILITIES AND CHILD DAYCARE CENTERS

INSTRUCTIONS:
Post a copy in a prominent location in facility, near telephone.
Return a copy to the licensing office. Licensee is responsible for updating information as required.

NAME OF FACILITY	ADMINISTRATOR OF FACILITY

FACILITY ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER
	( )

I. AFFIRMATION STATEMENT

AS ADMINISTRATOR OF THIS FACILITY, I ASSUME RESPONSIBILITY FOR THIS PLAN FOR PROVIDING EMERGENCY SERVICES AS INDICATED BELOW. I SHALL INSTRUCT ALL CLIENTS/RESIDENTS, AGE AND ABILITIES PERMITTING, ANY STAFF AND/OR HOUSEHOLD MEMBERS AS NEEDED IN THEIR DUTIES AND RESPONSIBILITIES UNDER THIS PLAN.

SIGNATURE	DATE

II. ASSIGNMENTS DURING AN EMERGENCY (USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

NAME OF STAFF	TITLE	ASSIGNMENT
1.		DIRECT EVALUATION AND PERSON COUNT
2.		HANDLE FIRST AID, AS NEEDED
3.		TELEPHONE EMERGENCY NUMBERS
4.		TRANSPORTATION, IF NEEDED
5.		OTHER (DESCRIBE)
6.		

III. EMERGENCY NAMES AND TELEPHONE NUMBERS (9-1-1 NOT ACCEPTABLE)

FIRE/PARAMEDICS	POLICE OR SHERIFF
RED CROSS	OFFICE OF EMERGENCY SERVICES
PHYSICIAN(S)	POISON CONTROL
HOSPITAL(S)	AMBULANCE
DENTIST(S)	CRISIS CENTER
CHILD PROTECTIVE SERVICES	OTHER AGENCY/PERSON

IV. FACILITY EXIT LOCATIONS (USING A COPY OF THE FACILITY SKETCH [LIC 999] INDICATE EXITS BY NUMBER)

1.	2.
3.	4.

V. TEMPORARY RELOCATION SITE(S)

NAME	ADDRESS	TELEPHONE NUMBER
		( )
NAME	ADDRESS	TELEPHONE NUMBER

VI. UTILITY SHUT—OFF LOCATIONS (INDICATE LOCATION(S) ON THE FACILITY SKETCH [LIC 999])

ELECTRICITY

WATER

GAS

VII. FIRST AID KIT (IF REQUIRED)

VIII. EQUIPMENT

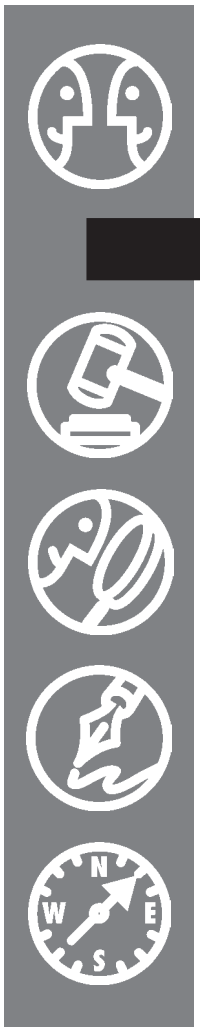
SMOKE DETECTOR LOCATION (IF REQUIRED)

FIRE EXTINGUISHER LOCATION (IF REQUIRED)

TYPE OF FIRE ALARM SOUNDING DEVICE (IF REQUIRED)

LOCATION OF DEVICE

LIC 610 (10/92) (PUBLIC)



Student Resource Guide

10. Communication

Student Resource Guide: SESSION 10

Communication

OUTCOMES

When you finish this session, you will be able to:

- Identify effective ways to ensure the DSP's understanding of individuals.
- Identify ways to modify communication to ensure understanding.
- Identify ways to resolve conflict by using active listening and "I" messages.
- Describe ways to overcome communication barriers to expression.
- Identify ways to support individuals' communication in their daily routines.

KEY WORDS

Active listening: This kind of listening requires that a person hears the words, figures out what they mean, and responds to the words in his or her own words.

Communication: Sharing thoughts, views, and feelings.

Communication boards: Electronic modes of communication that individuals carry with them.

"I" statements: Talking about a conflict from one's own point of view.

Modes of communication: The ways in which language and communication can be expressed.

Nonverbal: Communication that is expressed without words.

Sign language: The mode of communication used in the deaf community. Sign language combines the use of hand shapes, hand and arm movements, facial expressions, gestures, and body language in a structured and conventional manner to express thoughts, views, and feelings.

Opening Scenario

You may remember Matthew from the last session. He is an 8-year-old boy with cerebral palsy. Because of his developmental disability, Matthew has trouble talking and being understood when speaking words. In his Individual Program Plan (IPP), Matthew has a goal to use a variety of different ways to communicate. Susan, a DSP in the home is very fond of Matthew and has been trying to get him to practice talking more. Lately Susan has stopped using Matthew's picture communication system with him and ignores Matthew when he uses gestures or sign language. Matthew has been trying to ask her for a drink of juice using his picture system. Susan has ignored him, saying to him, "Matthew, you just need to learn to talk." Matthew tries using the sign he knows for drink. Susan again ignores him saying, "I don't understand that stuff. Matthew, you really can try to tell me in words." Matthew is very frustrated and just can't get the words out. He is very thirsty and angry. He falls to the floor and starts screaming and crying.

Communication

Communication is a very important tool in the DSP toolbox. Good communication will help the DSP reduce confusion and frustration and improve the quality of life for everyone in the home. Good communication skills can reduce DSP burden. Good communication skills are a vital component to decision making and problem solving. It is the basis for recognizing the needs of the individual and providing high quality support. Knowing how to communicate with simple, clear statements will lead to more positive interactions with the individuals you support, their families, co-workers, and community members.

This session will enhance DSP's skills related to:

- Communicating with individuals.
- Facilitating individuals' communication with others.
- Communicating with co-workers and community members.

What is Communication?

Communication is about sharing thoughts, views, feelings, needs, and preferences. There are three parts to all communication:

1. Sender
The individual with something to communicate

2. Message
What the individual wishes to communicate

3. Receiver
The person to whom the message is given

When an individual decides to send a message, the intent is to:

- Express something meaningful to him or her.
- Achieve a purpose.
- Share thoughts, views, and feelings with other people.

Reasons for Communicating

Why do people communicate with each other? People have many different reasons to communicate during the course of each day. One very important reason for communicating is to gain more control of our lives and to participate in our communities. More specifically, people communicate in order to:

▶ Give and get information

For the DSP, this could mean giving information to parents or family members about an individual's progress or letting the regional center know about an unusual incident. It could mean asking everyone in the program his or her opinion on an activity before deciding what to do. Or you may need to check with the regional center, your administrator, and the family before changing the way in which you approach an IPP objective. For individuals, this could mean asking about the day's plans, meals, what to wear, or when they want to see their friends. It includes asking questions and offering thoughts, views, or understandings.

▶ Express feelings

Individuals may want you to know when they have had a great day or when they are feeling bad.

▶ Solve problems

You may need to communicate with two individuals at your program to work out problems and to help those people solve their own issues.

▶ Learn new things

Individuals will need to know how to gain skills, such as oral health and hygiene skills, cooking, taking care of their money, or how to make their needs known.

▶ Persuade others

Individuals may want to have others see things their way. This could mean choosing clothing different from what was offered or having your supervisor consider additional funds for the person to go on a shopping trip.

▶ Make decisions

The DSP communicates with many people about how to make decisions that affect individuals in their programs. Maybe you are trying to figure out how to deal with someone's behavior. There might be communication among the staff, the consultants, other programs, and the regional center so the best decision is made.

▶ Build relationships

The DSP communicates with community members, neighbors, and friends and with individuals he or she works with and supports. All relationships happen using some form of communication. Individuals use communication skills to get to know other people; for example, finding out what the other people like to do.

Verbal and Nonverbal Communication

Verbal Communication

Verbal communication is the most common way individuals exchange information. Verbal communication is a complex skill, which requires attending to another person's hearing, thought, and speaking abilities. There are many points at which a breakdown could occur when using verbal communication. Verbal communication can be broken into four parts.

1. *Organizing the message.* This begins with the thought process of what the individual wishes to say.
2. *Sending the message.* The individual transfers the thought into spoken words, which are delivered to another person.
3. *Receiving the message.* The person receiving the message hears the message and attends to it.
4. *Processing the message.* The brain of the person receiving the message decides what the intended message means.

Excerpted from the *Caregiver Manual & Resource Guide for Southwest Florida*, Florida Gulf Coast University, 2002.

Nonverbal Communication

Nonverbal communication is communication that is expressed without words. Sometimes a sender's message gets mixed up, and the receiver doesn't understand it. At these times, you have to rely on your nonverbal communication. Nonverbal communication is often more effective since there is less chance for breakdown to occur. Generally the receiver needs to attend to the sender and see the nonverbal communication to understand it. Nonverbal communication can also be used to overcome other barriers to communication, for example difficulty speaking due to cerebral palsy. Following are some examples of nonverbal communication:

- **Facial expressions**

You may be able to tell what an individual is feeling by his or her facial expression. For example, usually a smile means the individual is happy, and a frown means that he or she might be sad.

- **Gestures**

These are hand, body, and facial movements that have meaning. Examples are putting your hands up as if to say "I don't know," or shaking your head to say "Yes" or "No," or waving to an individual in order to say, "Come closer, please."

- **Volume of voice**

You usually know how people feel if they are yelling, or if they talk very softly.

- **Physical closeness**

Standing close to people usually means they know each other well. Most people try to stay about an arm's length away from the person to whom they are talking.

Modes of Communication

Now you know that communication can be either verbal or nonverbal. The variety of ways communication can be expressed are called **modes of communication**. Modes are either verbal or nonverbal.

Common modes of communication include:

▶ Spoken language

Spoken language is the mode of communication that uses speech in words and sounds that are conventional and structured. Individuals with developmental disabilities may understand spoken language but not have developed speech skills. They may use speech mixed with other forms of communication to make their needs known.

▶ Written language

Written language is not always written in full sentences or spelled correctly. It is meaningful communication when the sender and receiver understand the context of the written language. For example, if an individual is in the grocery store and writes the word "cheese," she or he may wish to buy cheese. However, if the individual is in the kitchen with the refrigerator door open and writes the word "cheese," this time it may mean, "Help me find the cheese."

▶ Sign language

Sign language is the mode of communication used in the deaf community. In the United States, the standard sign language is American Sign Language. It combines the use of hand shapes, hand and arm movements, facial expressions, gestures, and body language in a structured and conventional manner to express thoughts, views, and feelings. American Sign Language has its own alphabet, words, and syntax. The American Sign Language alphabet can be found in Appendix 10-A.

▶ Sign systems

Sign systems are based on American Sign Language and have been adapted to the needs of individuals who are in schools and whose learning styles limit their use of spoken language. Many individuals who have developmental delays use signs that combine parts of American Sign Language and local, school, or home-based signs. The American Sign Language dictionary listed in Appendix 10-B provides a basic list of words for the DSP to use as a reference tool.

▶ Communication books

Communication books are a mode of communication that contain pictures, words, photographs, or symbols. They can be used separately or combined in one book. Individuals who use these books might point to the message they wish to send or use the book in combination with speech or even with signing. Communication books are developed based upon each individual's needs and abilities.

▶ Communication boards

Communication boards are electronic modes of communication that individuals carry with them. Some individuals use a board that has letters on it, like a computer keyboard. They point to the letters that spell words so someone can understand them. Some people have electronic systems that use pictures or symbols or that attach to computer monitors. Some systems have a voice that repeats the word, sign, or symbol to which the individual points.

▶ Behavior

Behavior can tell you a lot if you "listen" to what it is saying. Among other things, it gives you information about what individuals want, when they are unhappy, and their interest in being social.

Some of the things that behavior can communicate are individuals':

- Preferences or choices
- Requests for objects
- Requests for assistance
- Requests for affection
- Desire for attention
- Feelings

The purpose of all modes of communication is to support individuals as they make choices and interact. It is important that DSPs are able to identify the modes of communication that individuals use and support them in using those modes.

ACTIVITY

"Listening" to What Behaviors Are Communicating

Directions: Read the following behaviors in the left column. In the right column, write down what you think those behaviors are communicating.

Behavior	What could that behavior be communicating?
Example: Bob points to an apple on the table and then points to his mouth.	Bob wants to eat the apple.
Marta smiles and shakes your hand.	
Dan comes to you with a toothbrush in one hand, toothpaste in the other hand, and a confused look on his face.	
Lisa spits out peas onto the table.	
Juan tugs at your sleeve.	

Communication Disorders

You have learned about some of the ways that people communicate. In part, the mode of communication is influenced by communication disorders that an individual may have. Some of the things that can get in the way of an individual being understood include:

- Limited or no speech.
- Hearing loss.
- Poor control of muscles needed to produce speech (like with cerebral palsy).
- Damage to the part of the brain that controls speech.
- Challenging behaviors.
- Day-to-day health of the individual.

When making your needs known is hard, it's difficult to meet people and to do the things you enjoy, and it may make an individual behave in a negative way.

There are two kinds of communication disorders:

1. Speech Disorders

Speech disorders relate to the muscles that people use to form the sounds of speech. There are four types of speech disorders:

- **Abnormal pitch**

This is a condition in which an individual's voice is high-pitched or very deep. It is similar to the difference between a man's and a woman's voice. Men's voices are usually lower toned or pitched than women's.

- **Abnormal quality**

This is a disorder in which an individual makes the sounds, but the sounds last longer or shorter than usual or are molded together in a way that make it hard to understand. It is similar to a tape recording that has gotten too old so that the tape moves slowly or a tape recording that, at the end of the tape, moves fast so the voices sound high pitched and fast.

- **Excessive loudness**

This is a condition in which individuals almost shout rather than talk in a normal voice.

- **Incorrect articulation**

This is a condition where the individual's mouth makes sounds incorrectly. Perhaps a "p" is pronounced with a voice and breathing like a "b" sound. Another example is an individual's inability to make the sound at all with his or her lips, which keeps the listener wondering what he or she meant.

Sometimes speech muscles that don't work cause a speech disorder. You may hear a speech therapist who works for someone you support talk about this. Some individuals may miss sounds when they are talking, like saying "nake" for "snake," or "moke" for "smoke." Or an individual might say "dis" and "dat" instead of "this" and "that."

2. Language Disorders

Language disorders are sometimes caused by damage to some area of the brain. With a language disorder an individual might be limited in his or her ability to understand language. This is called receptive language. An individual's ability to talk might be limited. This is called expressive language. Or, a person may talk as if they are much younger.

Supporting Individuals During Daily Routines

Once the DSP has identified the individual's modes of communicating, his or her responsibility is to encourage communication during daily routines. Each time the DSP and the individual are together is a chance to initiate communication. This will help individuals feel more in control of their lives and participate in their communities in a meaningful way.

Following are some suggestions for supporting individuals' communication every day:

- **Create opportunities during the day to promote conversations with individuals.**

For example, talk to the individual while doing personal care, oral hygiene, eating, and dressing routines. These are opportunities for you to learn more about individuals' modes of communication and their preferences.

- **Allow individuals time to respond.**

Sometimes people are so busy that they ask a question and don't really wait for a response. How many times have you asked someone "How are you?" without waiting to hear their answer? It is important to keep in mind that some individuals may take longer to understand a question. Others may need time to formulate their response. Sometimes the response may take a very long time.

- **Acknowledge the individual's attempt to communicate.**

Remember that everyone communicates in different ways. Even a small sound or gesture needs to be noticed. That will let the individual know that what they are trying to tell you is important to you.

- **Provide opportunities to make choices and avoid making decisions for people.**

If you have known an individual for a long time, you often think you know what they need and want. However, individuals' needs and preferences may change over time. It is essential to create opportunities for individuals to communicate their needs and preferences. One way to do this is to provide "choice opportunities." Choice opportunities are situations in which someone is provided with a choice between two or more items or activities. You can offer choices throughout the daily routine. For example, "Do you want to brush your teeth with Crest® or Colgate®?" "Do you want pizza or steak for dinner?" "Would you like to go for a walk or go to a movie?"

- **Talk to the individual about routines as they occur.**

It is important to talk about activities as you do them. Imagine if you had to go through a day in total silence. By talking through each activity, you increase the chances that the individual will learn the words, as well as the order of the activities. You should talk through routines with the individuals you support even if you don't know if they really understand. You don't always know what the individual understands.

What the DSP teaches about communication is as important as how it is taught. If an individual is communicating through pictures or graphic symbols, the DSP may need to spend more structured time to assure that the symbol used matches what the individual wants to communicate. The DSP would also want to use those symbols throughout the day for routines and activities so that there are many chances to practice them. For someone who is learn-

ing to make choices through facial expressions, you would also want to make sure that there are a number of chances for him or her to make a choice and to practice facial expressions.

Strategies for Making Communication a Part of Every Day

- Use words when the individual feels something (sore, hurt, tired).
- Name objects during daily routines.
- Describe everything as you assist the individual (dressing, serving meals).
- Point to pictures of objects in books and say them clearly.
- Point out objects while on a walk, in the car, at the park, or in the store.
- Have the individual watch your mouth as you say words.
- Speak in short sentences when giving directions.
- Be sure to pronounce the entire word.
- Encourage progress in making sounds and saying words.
- Be sure your movements are simple when teaching.
- Encourage individuals to use all of their senses.
- Listen carefully to what the individual says or attempts to say.

ACTIVITY

Supporting Individuals in Their Daily Routines

Directions: Think of an individual whom you support and one routine that they do on a daily basis (for example, brushing their teeth, bathing, eating breakfast). Using the Strategies for Making Communication a Part of Every Day *and your own strategies, write down three ways that you can encourage that individual's communication during that routine.*

Daily routine:_____

Strategies I use to encourage communication during this routine:

. . . . . .

1.

. . . . . .

2.

. . . . . .

3.

Communication with Co-Workers

Until now, this session has focused on communicating with individuals and facilitating individuals' communication. We will now discuss how DSPs communicate with each other and with other team members.

Active Listening

Each of us shares the responsibility for good communication. Listening is a key skill to good communication. Realistically the life of a DSP doesn't always lend itself to those private moments when listening would be easy. When you add more people and their interests, you've increased the difficulty of listening. Effective DSPs develop the skills to both assist individuals to communicate and to listen very carefully. Another role of the DSP is to learn how to communicate effectively with other team members, including:

- Family members
- Regional center staff
- Licensing staff
- Administrators
- Neighbors
- Co-workers
- Work or program staff

We all need to take the time to figure out the words we hear. We may even need to ask the person who said them if we heard correctly before we respond. That means that we have to pay very close attention to each word the person is saying. This is called **active listening** because it involves a lot of energy. The steps for active listening are:

- Hear the words.
- Figure out their meaning.
- Respond to the meaning in your own words.

Hearing what a person says is not the same as listening. It happens when you take time to see if what you understood was what the person really meant. Your response is a way to "check" if the individual or fellow DSP feels heard and that the communication was understood. The ways that the DSP can do this are to:

- Ask the speaker questions to see if the understanding is correct.
- Re-word the statement and say it back for clarification. For example: "What I hear you saying is that you feel frustrated. Is that correct?"

Sometimes it is important to not only hear the words but to "actively listen" to the individual's behavior or other modes of communication.

Conflict Resolution

To this point, this session has focused on assisting individuals learn how to communicate and DSPs becoming good communicators. There will be times, even with good communication, when people disagree. For example, the planning team may disagree about the goal an individual may have, a parent may disagree with the support given to an individual, or two individuals living together can disagree about what TV program to watch. There are many times that a DSP will encounter conflict. It is important to know how to effectively and professionally resolve conflict.

Helping individuals be more independent may also mean teaching individuals how to resolve conflicts, how to solve their own problems, and how to make decisions. With those skills, the individuals you support can be more confident in their own abilities.

ACTIVITY

Stepping into Another Person's Shoes

Directions: Pair up with another person in the class, and ask the following questions. Write your partner's answers below.

1. Did you share a bedroom while growing up?

2. Do you share a home with someone now?

3. Was there ever a time when you didn't like sharing a room?

4. What made sharing a room or a house difficult?

ACTIVITY

Conflict Brainstorm

Directions: Write down all of the words you can think of that mean "conflict" to you.

Conflicts is:

Sometimes what you see as a disagreement is seen very differently by the other person. One important part of understanding conflict is to see things as the other person sees them.

ACTIVITY

The Way I See It

Directions: Think about a conflict or disagreement you are currently involved in. It can be in your work life or outside of work. Imagine that right after class, you are meeting with the person with whom you have a conflict. Maybe you had a disagreement last night and have not seen that person since. Prepare for that meeting by writing down your answers to the following questions.

1. What is the disagreement?

2. What will you discuss with the person when you meet?

3. What result do you want from the meeting?

ACTIVITY

Another Way to See It

Directions: Now imagine that you are the person with whom you have a conflict. Prepare for that same meeting by writing down your answers to the following questions.

1. What is the disagreement?

2. What will you discuss with the person when you meet?

3. What result do you want from the meeting?

Method for Managing Conflict

Following is a method that you might use for managing conflict. This method may be helpful both at work and at home.

▶ **Separate the person from the problem.**

Put yourself in the other person's place, like you just did in the activity. Sometimes, something about the person is just annoying to you. It could be his or her voice or the way he dresses, or you don't like the way he lives his life. But you have to look just at the problem in order to resolve things. You have to control your emotions, even if the other person is doing things that really bother you. Mostly, you want to make sure that you understand each other.

▶ **Figure out each person's goals and interests.**

Concentrate on what each person wants most and try to find the places where there is agreement. Be open to meeting someone half way. Everyone should define how they see the problem, and the problem has to be discussed before solutions can be.

▶ **Find answers that work for both people.**

There are many different ways to find possible answers to the problem. One way is brainstorming, which you'll practice a little later. Explore all kinds of options before making a decision.

▶ **Try to agree.**

You may not come to agreement on a solution the first time that you discuss the problem. Sometimes, you have to review all of the options several times. Some people may want to think it over or discuss it with others. Once there is agreement, decide what the next steps might be. Who will do what, and when will that be done? Then figure out how to decide if the solution really worked.

ACTIVITY

Brainstorming

Directions: Break into small groups. Read the following scenario. Next, brainstorm some ways that the money could be spent. Every idea that group members suggest must be written down. Then, as a group, try to come to agreement on one of the options.

Scenario

One of the parents whose child lives in the home where you work just gave you $500. The parent said that the money can be spent in whatever way the whole group decides. The only restriction is that everyone has to be part of the decision making process.

Our group's ideas for how the money should be spent:

We decided on this idea:

Rules for Conflict Resolution

Below are some rules for resolving conflict. Rules like these are often used to help couples to communicate better. When you are discussing a difficult problem:

- **Use "I" statements.**

  Using "I" statements means that you need to talk about the problem or disagreement from your own point of view. Look at the difference between the following statements:

  "I feel much better when you call to let me know you'll be late."

  "You never come home on time."

  The second example puts the blame for the problem on the other person and can make it difficult to resolve the problem.

- **Be willing to resolve the problem.**

- **Do not engage in name calling.**

- **Stay in the present and stick to the topic.**

  Staying in the present and sticking to the topic means that you shouldn't bring up problems that are not related to what you are discussing right now. Consider the following statements:

  "You are acting just how you used to act five years ago when you never called home if you knew you would be late."

  "And I also am sick of you leaving your dirty clothes on the floor instead of putting them in the hamper."

  Statements like these take the focus off the problem at hand and make resolving it seem much less manageable.

- **Don't interrupt the person who is talking.**

- **Recognize that the other person has his or her own feelings.**

- **Ask questions to understand the other person's side.**

Spencer Johnson, M.D.

ACTIVITY

Observing for Effective Communication

Directions: Watch the video scenario. As you watch, look for good and bad examples of communication. Break into small groups and make a list of the good and bad examples you observed. Think of how the bad examples could have been communicated in a better way. As a group, you should be prepared to discuss what you observed with the whole class and to make suggestions for improving upon the bad examples.

EFFECTIVE COMMUNICATION

"Good" communication	*"Bad" communication*

PRACTICE & SHARE

During this session you learned about modes of communication and communication disorders. Think about an individual whom you support. What modes of communication do they use most often? Do they have any communication disorders? How can you assist them in communicating more effectively?

Communication

1	A	B	C	D
2	A	B	C	D
3	A	B	C	D
4	A	B	C	D
5	A	B	C	D
6	A	B	C	D
7	A	B	C	D
8	A	B	C	D
9	A	B	C	D
10	A	B	C	D

1. **To communicate with someone who has difficulty expressing thoughts and feelings verbally, you should:**
   A) Show pictures and ask them to make a choice.
   B) Ask them to repeat themselves until you understand.
   C) Ask them to speak louder.
   D) Prompt them with your own reply.

2. **An example of how an individual uses behavior to express a greeting is:**
   A) The individual walks away from you when you say "Hello!"
   B) The individual comes to you and shakes your hand.
   C) The individual signs to you.
   D) The individual looks at you when you say, "Hello!"

3. **The DSP ensures good communication with individuals by:**
   A) Speaking clearly.
   B) Listening to the individual, watching his or her behavior and repeating back to the individual for understanding.
   C) Talking loudly.
   D) Looking at the individual when he or she talks.

4. **Using an "I" message means to:**
   A) Tell team members what you want them to do
   B) Use the word "I" before asking for help
   C) Be a good listener
   D) Hear the other person's words, think about their meaning and respond to the meaning.

5. **An example of how to be a good listener is to:**
   A) Walk away from the speaker if you don't agree with what is being said.
   B) Always look at the speaker, smile and be happy.
   C) Watch body language, wait for answers and read facial expressions.
   D) Ask the speaker to repeat herself.

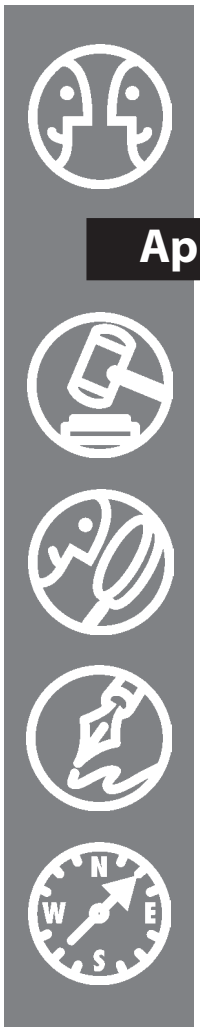
6. **Nonverbal ways that individuals sometimes communicate include:**
   A) Using facial expressions, gestures and pointing.
   B) Being quiet.
   C) Singing out loud.
   D) Looking around the room and sitting down silently.

7. **Social skills that help communication include:**
   A) Showing attention to the individual while talking.
   B) Laughing and enjoying communication.
   C) Asking the individual to repeat himself.
   D) Walking while talking.

8. **The most serious barriers to communication include:**
   A) Television watching and loss of sleep.
   B) Hearing loss, limited use of muscles or day-to-day health of the individual.
   C) Having many needs.
   D) Having no friends

9. **Ways to improve communication include:**
   A) Avoid anticipating the individual's needs.
   B) Using drawings for picture communication.
   C) Sitting with the individual after mealtime to talk.
   D) All of the above.

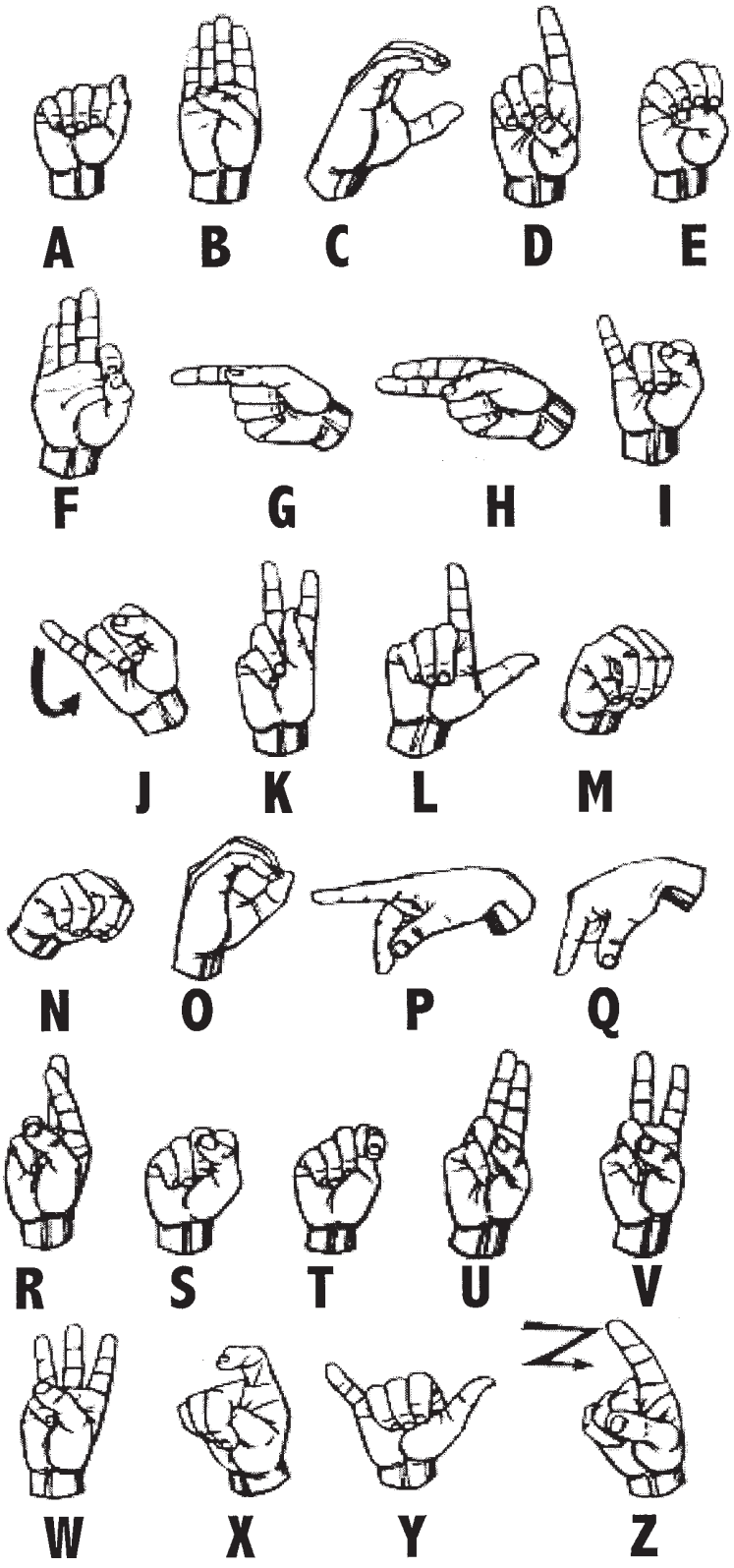
10. **One way the DSP can improve communication:**
   A) Acknowledge the individual's attempt to communicate.
   B) Be sure to look at the individual when giving directions.
   C) Provide five choice for the individual.
   D) Give the individual candy or fruit whenever he or she asks for something.



Appendices

Appendix 10-A

American Sign Language Manual Alphabet



Appendix 10-B

Saying Words with American Sign Language

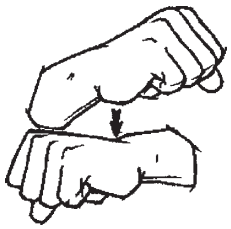
Excerpted from Vicars American Sign Language Course Introductory Signing Concepts at www.lifeprint.com/concepts.htm

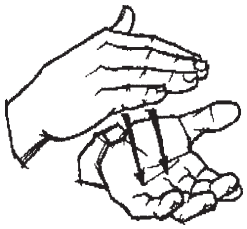
Home

The sign for "home" is made by touching your fingers and thumb together at the mouth. Then move your hand from your mouth to your right cheek.

Work

The sign for "work" is made by shaping both hands into the letter "s." With your palms facing downward, tap your left wrist or the back or your hand a few times with your right wrist.



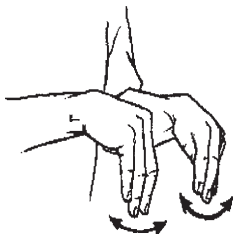


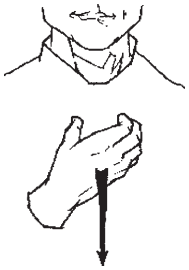
School

The sign for "school" is made by clapping your hands. Repeat two or three times.

Store

The sign for "store" is made by bending both wrists and pointing both hands down. Pivot both of your hands toward and away from your body. Repeat a few times.





Hungry

The sign for "hungry" is made by forming your right hand into the letter "c." Move your hand down the middle of your chest, starting under your throat. Note: Some people use the sign for "wish," and prefer to start "hungry" from a slightly lower position.

Thank You

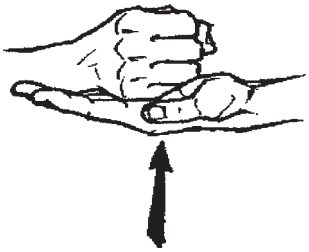
The sign for "thank you" is made by touching your lips with one or both of your hands. Your hand(s) should be flat. Move your hand(s) away from your face, palms upward. Smile. Note: Most people use only one hand for this sign.

Sad

The sign for "sad" is made by placing both hands in front of your face, palms in. Bring both of your hands down the length of your face. Tilt your head forward slightly, and a make a sad face.

Love

The sign for "love" is made by crossing both hands over your heart. Your hands may be closed or open, but the palms should face toward you.

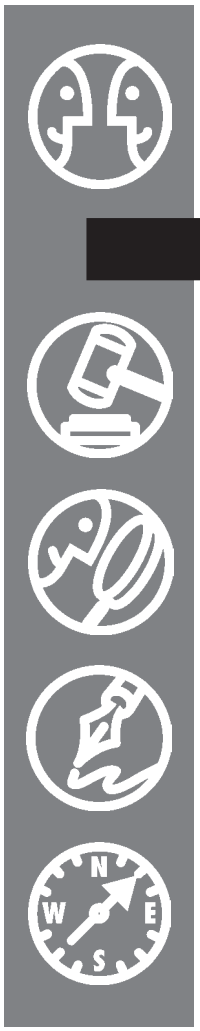


Help

The sign for "help" is made by closing your right hand. Place your right hand on the outstretched palm of your left hand. Raise both hands. Note: Many people make this sign by placing the left "s" or "a" hand on the right "b" palm.

Bathroom

The sign for "bathroom" is made by forming the right hand into the letter "t." With your palm facing away from you, shake your hand in front of your chest.



Student Resource Guide

11. Positive Behavior Support

Student Resource Guide: SESSION 11

Positive Behavior Support

OUTCOMES

When you finish this session you will be able to:

- Identify factors that promote positive behavior.
- Observe and assess the communicative function of behavior.
- Identify aspects of an individual's quality of life that influence behavior.
- Identify aspects of the physical environment that influence individual behavior.
- Observe and assess for a positive environment.

KEY WORDS

Behavior Function: What the individual is getting or avoiding through the behavior.

Communicative Intent: What the behavior or action is trying to communicate or tell us.

Positive Behavior Support: Supporting individuals with challenging behavior.

Replacement Behavior: The new skills and behaviors that we want to teach the person as an alternative to the challenging behavior.

Opening Scenario

David is 25 years old and has lived at his current home for three years. He tends to throw things and bite himself when he is not getting his needs met. He communicates in two- to three-word sentences, but he can be difficult to understand. He takes several psychotropic medications. David doesn't like to do chores (especially laundry) and will use his behavior to get out of them. He loves to watch sports on TV and would choose to do this all of the time if he could. He prefers simple meals like cereal for breakfast, peanut butter sandwiches for lunch, and hamburgers for dinner. David attends a day program four days a week and does janitorial work at McDonald's for one hour, one day a week.

Darrell is a new employee at the home and is concerned about David's behaviors. He is afraid that David will hurt himself or him with his biting. He doesn't know why David behaves this way, and he is not sure how to respond whenDavid has an outburst. Where should he begin?

Overview to Positive Behavior Support

After reading through the scenario above, you might find yourself thinking of a similar situation where you were unsure of how to respond to the actions or behaviors of an individual you support. You may have found yourself wondering where to begin and what you should do to help the individual communicate with others in a more socially appropriate manner. You may also be thinking of examples of challenging behavior you have seen in your work that you would like to discuss. Over the two years of this training, we will spend three sessions learning about supporting individuals with challenging behavior, or **positive behavior support**. This first session will focus on creating an overall positive environment for your facility. A positive environment values and honors individual wants and needs, as well as the needs of the whole group, by understanding the communicative function of challenging behaviors an individual demonstrates. The two sessions in Year 2 will focus on understanding why challenging behavior is occurring, analyzing the behavior, and implementing an individual positive behavior support plan to deal with challenging behaviors.

In this session, you will examine the overall quality of the individual's life and how this might impact his or her behavior. You will also learn how to incorporate into the daily life of the individuals you support small changes that can have a big impact on their behavior. It is important to remember that when people have choices about the activities and routines in their lives and these choices are honored and respected, the happier they are and less likely they will be to exhibit challenging behavior. Creating a positive environment that respects and values individual preferences and choices, as well as the needs of all the residents, will not only make the individuals you work with happier, it will make your job of supporting them easier.

The Role of the DSP in Positive Behavior Support

The role of the DSP in positive behavior support is to understand the challenging behavior of the individuals you support, figure out why it is working for the individual, and plan what to do about it, including teaching socially appropriate alternatives to the behavior.

The Importance of the DSP Knowing About Behavior

In your role as a DSP, you often find yourself supporting individuals whose challenging behavior seems to interfere with their ability to live a rewarding and productive life. Assisting individuals with challenging behavior can be difficult. The challenging behaviors may range from simple but perhaps annoying to severe challenging behaviors that can be unpleasant and unsafe for both the individual and others around him or her. The solutions to these extremely challenging behaviors often need to be developed by a team approach involving the assistance of a behavior specialist. This approach, referred to as a positive behavior support plan, can be described as a planned, intensive process that looks at all aspects of the individual's life and designs interventions that will allow the individual to be successful across all environments. When this happens, you will often be part of the team analyzing the behavior and will assist in developing and carrying out the recommendations of the team. We will discuss this process in more detail in Year 2.

Often though, the challenging behaviors that you will come across on a daily basis are less severe and can be dealt with using simple solutions. By using your observation skills to figure out what the individual is trying to communicate with the behavior, you can come up with simple but creative solutions that can be easily implemented and very effective. Supporting an individual with challenging behavior starts with knowing the individual, not just looking at him or her as someone who needs "fixing."

Let's begin by figuring out what is meant by challenging behavior and positive behavior support with a quick review of the history of behavior support and how it has changed over the years.

A Brief History of Positive Behavior Support

In the Past…

We used to think that the activities in which individuals engaged; the places where they lived, worked, and played; or the people they spent time with had nothing to do with their behavior. We didn't think these daily activities affected an individual's life. We placed individuals with disabilities in environments that made it easier for the people working with them but were surprised when the results were not successful for the individuals. We now know that all of these factors greatly affect individuals' behaviors.

We often grouped individuals with disabilities with other individuals who had disabilities in institutions, schools, work, homes, and recreation centers, assuming their needs were similar. We thought that not only would the individuals feel more comfortable with other individuals who also had disabilities, but also that we could provide support and instruction for others with similar needs. What we found was that these individuals learned only how to act like other people with disabilities. They were unable to function well in society because they had not learned how to act in socially appropriate ways.

Individuals with disabilities used to have to earn the right to attend school or work with peers who did not have disabilities. Their families were told that their behavior had to be "under control" before they could ever participate in these environments. Over time, we realized how important these everyday activities, people and environments are to the overall quality of an individual's life. Every person who can breathe can imitate and learn behavior from the other people around him.

For example:

When we:	***They learned:***
Put kids that can't talk very well into a class with other kids that can't talk very well..	*Not to talk*
Put kids with challenging behaviors into a class with other kids who also have challenging behaviors	*More challenging behaviors!*
Put kids with autism in classes with other kids with autism	*How to act more autistic*

We also used to write behavior plans that relied almost entirely on rewards and punishments. Our support plans told us what to do *after* a behavior occurred. We weren't taught to figure out *why* a behavior occurred, only whether to reward it or punish it. We now know how important it is to try to understand why a behavior occurs and to teach the individual a new way to get the desired result with a more appropriate behavior.

Research has shown that individuals' behaviors are better when we provide the best environmental matches (regular education classrooms, real work settings, for example) and then identify and provide the supports necessary for their success. When we place individuals in segregated environments (with other individuals with severe disabilities), where they have no appropriate behavioral models from which to learn, their behaviors are less likely to improve.

What Is Behavior?

Behaviors are communication strategies people use to express their wants, needs, and feelings and to get their needs met. All of us have behavior. Behaviors don't happen without reason.

- All behavior is intended to communicate something. All behavior is communication!
- By "listening" to what the behavior is saying, we can discover the reason why the behavior is happening.
- There are always reasons for behaviors, even if we do not know those reasons right now.

What Makes a Behavior "Challenging"?

Behavior can be considered challenging when it affects an individual's life in a negative way. For example, a child learning to say "please" before they ask for an object is not a challenging behavior. In fact, we say the child has learned a "social skill." If the child has learned to scream when he or she wants something, we say the child has a "challenging" behavior. Generally, behavior is considered challenging if it:

- Causes harm to the individual or others.
- Causes damage to property.
- Prevents the individual from learning new skills.
- Causes the individual to be "labeled" as different, or undesirable.
- Prevents the individual from taking part in social and recreational activities.

Once it has been established that a behavior is challenging, your job is to observe and figure out how the challenging behaviors are "working" for the individual so that you can teach more socially appropriate alternatives, or **replacement behaviors**. Remember that challenging behaviors don't happen just to make you mad or to make you work harder.

What individuals do, where, and with whom have a lot to do with their behavior. When you look closely at these factors, you should be able to predict when, where and with whom the challenging behaviors are most and least likely to occur. Individuals use the strategies that have worked the best for them in the past. The following activity illustrates this concept.

OPTIONAL ACTIVITY

Communicative Intent

Directions: Watch the video scenario and discuss the following with someone at your table:

- From the individual's perspective, which behavior works best?
- Why?

What Is Behavior? (continued)

As the previous scenario shows, the best strategy is one that works the best for the individual. Your job is to identify and teach the individual a new, alternative strategy that works just as well as the challenging behavior; otherwise, the individual will have little motivation to give up the challenging behavior he is using.

Before you can decide on an alternative strategy to the challenging behavior, you must first examine the behavior and try to figure out:

- What the individual is trying to communicate with his or her behavior.
- The **behavior function**—that is, what is the individual getting or avoiding through the behavior?

Behavior Is Communication

Sometimes it is easier to figure out what an individual doesn't want when they are using a challenging behavior. Sometimes these are the behaviors that make it hard for the individual to be with other people. The individual might spit out food they didn't enjoy or push away the staff person who wants to help. Imagine if you didn't have words to use. How would you let someone know that something was making you unhappy?

Individual's behavior usually communicates three things:

- What the individual wants.
- What the individual doesn't want.
- When the individual wants attention.

How would an individual's behavior tell you that they want something?

- He might point to an apple on the table, which lets you know the individual wants the apple.
- The individual might come to you and shake your hand, which lets you know he wants to greet you.
- The individual might come to you with a toothbrush in one hand and toothpaste in the other and a puzzled look on her face. That might let you know that the individual needs some assistance.
- When you offer an individual a choice of foods for dinner, she might point to what she wants or look in the direction of the food she prefers.

Often, individuals just want someone to pay attention to them. Some individuals have learned that making loud noises gets the attention of the staff or that when there is a lot of activity, they need to wave their arms to get staff to focus on them. Or an individual might just pull at your arm to get your attention.

An individual's behavior will give you information about his or her interest and ability to be social, as well. An individual who doesn't use spoken words can often very clearly greet us and say goodbye. That individual can give a lot of information through facial expressions.

Remember the detective skills you learned in Session 8 as you looked for signs and symptoms of injury or illness? A good detective gets to know as much as possible about the individual she is observing. You get to know a person by spending time with him or her and learning what is usual for that individual, such as daily routines, behavior, way of communicating, appearance, general manner or mood, and physical health. If you don't know what is normal for an individual, you won't know when something has changed. A DSP needs to use good detective skills such as:

- Observation: looking at the individual and watching how he behaves.

- Listening: words, sounds, noises or cries (happy, sad, angry, for example) the individual may be making.
- Questioning: asking the individual what he wants or asking others if they know what the individual wants.

These same skills will help you to figure out what an individual's behavior is trying to communicate.

It becomes your job, as a professional, to be a detective and try to figure out:

- What the individual wants.
- What the individual doesn't want.
- When the individual wants attention.

Going Beyond Observation

Being a good detective goes beyond just observing. You also need to know the individual as a person to know what he likes and doesn't like, and how he has acted in other situations. You have all been able to determine what the individuals you support are telling you by:

- Knowing what they prefer.
- Watching them over time.
- Understanding how they show their emotions.
- Knowing what they like and don't like.

In other words, you have a relationship with the individuals you support that has developed over time. You can use this information to help understand what the individual is trying to communicate.

Communicative Intent

As you were discussing the nonverbal communication methods of the individuals you support during the last activity, you probably found yourself trying to figure out the purpose of each method or action used by the individual. Each method or action that was described was for a purpose. That purpose was to meet a need of the individual, and they were using the method to tell someone what that need was. What a behavior or action is trying to communicate or tell us is called **communicative intent**.

You can begin to define the "communicative intent" of an individual's challenging behavior by keeping track of the behavior and what we think they are trying to communicate with it. A communication chart, such as the one that follows, is helpful in defining the behavior and its intent. The DSP can list the specific challenging behavior on the left side and what it might be communicating on the right.

ACTIVITY

Communicative Intent I

Directions: Watch the video scenario and complete the chart. You will begin defining the communication by listing challenging behaviors on the left side of the chart and describing what the individual might mean by those behaviors on the right side.

Challenging Behavior	It May Mean

It is critical that you become good at defining the challenging behavior and deciding what the individual is trying to communicate with the behavior. It is also important that you discuss specific challenging behaviors with others who are around the individual and come to agreement on what the specific behavior is and the communicative intent of the behavior.

In your group, watch the video scenarios and record on the chart below your thoughts about each challenging behavior and what it is trying to communicate.

ACTIVITY

Communicative Intent II

Directions: Watch the video scenario. Record your thoughts about each challenging behavior, what it is trying to communicate, and how the DSP communicated.

Challenging Behavior	It May Mean	DSP Communication

ACTIVITY

Positive Behavior Support Video Demonstration

The following activity will help you identify what the individual might be communicating with a certain behavior. You will view a short video of David and then answer the following questions:

1. What were some of David's challenging behaviors that you observed?

2. What do you think that each of David's challenging behaviors was communicating?

3. How did the DSP communicate with David?

4. What did the DSP's behaviors communicate?

Creating "Win-Win" Situations

As you watched the video scenarios and identified the communicative intent of the individuals, you may have noticed that one of the things that "triggered" or started the behavior was the DSP telling the individual to do something. In some of those cases, by demanding that the individual do something right now or in a certain way, the DSP created a situation where the individual responded with challenging behavior. This often happens when the DSP feels rushed or under pressure to get things done quickly; the demand is not made deliberately to upset the individual.

Think about your own work day and times that either your supervisor or a coworker has asked you to do something. If someone says, "You need to clean this mess up right now!" and does not consider that you may be doing something else or that it is someone else's job, you might not feel like doing it. Had she said, "I see a mess here that needs cleaning up. Can you do that now, or are you doing something else? Perhaps we could get someone else to help," you might be more willing to help because she took the time to find out if you were already busy and offered to get help if you were.

How you make a request of someone or respond to someone's request has a dramatic impact on whether or not the individual will comply. If you ask someone in a manner that is respectful and courteous, he is more likely to want to do what you ask. If you consider your request or response before making it to the individual, you might prevent the challenging behavior. This is one of the simple changes you can make in your behavior that will have a very positive impact on the individual and his or her willingness to comply with your request.

Win-Win Responses

When you ask someone to complete a task or respond to an individual's request, it is helpful to consider:

- Is this an activity that the individual likes to do?
- Is this an activity that the individual knows how to do?
- Is the individual already doing something else?
- Does the individual have a ***choice*** about when or how to do the activity?
- Are you asking in a way that you would like to be asked?

ACTIVITY

Say It Another Way

Directions: Each scenario below is an example of a DSP making a request or responding to a request from an individual in a way that caused a challenging behavior to occur. Read each brief scenario and think of how the DSP could have made the request or responded to a request in another way.

Scenario 1

John, an individual with autism who is 35 years of age and lives in a family care home, is sitting on the couch watching his favorite game show. He watches the show every night and does not like to be interrupted during it. Juan is the DSP who asked John 20 minutes ago to take the dishes out of the dishwasher and has had it. He goes into the room and turns the TV off and says, "Juan, I told you 20 minutes ago to put the dishes away. Do it now." John starts screaming and throwing things.

What could Juan have done differently?

Scenario 2

Missy is a 20-year-old woman with developmental disability who is very social. She walks into the family room where everyone is watching TV after dinner and says, "I need some nail polish. Can we go to the store?" Sue is the DSP who has been working in the home for five years. She responds to Missy, "No, you don't need any nail polish." Missy gets mad and yells at her.

What could Sue have done differently?

Key Points About Promoting Positive Behavior

- What individuals are doing, where, and with whom affects their behavior.
- Behaviors are strategies individuals use to get their needs met. Part of your job is to figure out which social/communicative behaviors currently work best for an individual.
- All behavior is communication. By "listening" to what the behavior is saying, you can discover the reason for the behavior.
- How you make a request or respond to an individual can decrease the chances of a challenging behavior occurring.

Quality of Life

Darrell thinks about David's behavior and what David might have been trying to tell him. "Perhaps he wanted to be given a choice about when to complete his chore instead of being told to stop what he was doing and do the chore now. Maybe he wanted to finish the TV show before beginning the chore. Does it really matter to me when he completes his job?" Darrell begins to see that he created a battle by not giving David choices about how to use his free time. After all, it is his home, and he should be given the opportunity to enjoy his favorite activities. Darrell now sees that everyone needs to be able to participate in activities they enjoy and to make decisions about when and where they do some tasks in their lives. Even so, Darrell wonders how he will figure out what the favorite activities are of the individuals he works with and the activities that they don't like.

It's important to remember that quality of life issues are among the most important factors that influence behavior. If someone's life quality isn't what it could be, it can affect behavior.

The following activity will help you define what "quality of life" means for you and for the individuals with whom you work.

ACTIVITY

Quality of Life

Directions: Look at the boxes below and focus on the first section ("My Home"). Write three to five brief statements or phrases that indicate what you value about your HOME. (Examples: I live close to my job; I live with my family, spouse, friends, or alone; I value privacy and my stuff; I'm safe; I have good neighbors and a good view). Repeat for each of the other three sections.

My Home

Community

My Job

My Free Time

OPTIONAL ACTIVITY

Directions: Answer the following questions for the individuals in your facility.

Quality of Life Questions to Consider

1. What would increase or strengthen the individuals' friendships and social activities?

2. How can you help individuals to be involved in more activities in their home, school, work, and community?

3. How could you help individuals have more opportunity for making choices and be able to control more aspects of their lives?

4. How can individuals' self-esteem and confidence be strengthened?

5. What might interfere with individuals' abilities to have greater independence and quality of life?

Important Values in Promoting Positive Behavior Change

Quality of life values should be included in the lives of the individuals we support. Part of your role as a DSP, and as part of the support team for each individual you work with, is to figure out how to improve these quality of life values for each individual. How might you work at making sure these values are reflected in the every day life of the individuals you work with?

As you'll recall from Session 1, the following set of values guides the system that provides services for individuals with developmental disabilities in California:

- **Choice**

  Choices and preferences of individuals with developmental disabilities are encouraged, supported, and respected.

- **Relationships**

  Individuals with developmental disabilities have close, supportive relationships with friends, family, and their community.

- **Regular lifestyles**

  Individuals with developmental disabilities live, work, play, and carry out daily activities in natural, integrated community and home settings.

- **Health and well-being**

  Individuals with developmental disabilities are as safe, healthy, and happy as possible.

- **Rights and responsibilities**

  Individuals with developmental disabilities are treated with respect and fairness and are free from abuse, neglect, and exploitation.

- **Satisfaction**

  Individuals with developmental disabilities achieve personal goals and feel their lives are fulfilling.

Taken together, these values lead to a higher quality of life for individuals. In order to support positive behavior change, these important "quality of life" values should be part of the daily life of each individual with whom you work.

By making sure the individuals you support have these values included in their daily lives, you are improving the quality of their lives and reducing their need to use challenging behaviors to express themselves or to make their needs known.

OPTIONAL ACTIVITY

Important Values

Directions: Read the list of values and questions on the left side of the chart. As you read, think of individuals that you support and ask yourself how you might answer those questions about their lives. On the right side of the chart, write down some ways that each value could be included in the daily lives of the individuals with whom you work.

Values	***Ways to Include Values in Individuals' Daily Lives***
Choice • How much choice do individuals have throughout their lives? • Do individuals have choices from preferred options that they understand? • Do individuals have choice about when they perform necessary activities, such as chores? • How much are individuals involved in planning their days, evenings, and weekends? • How do individuals communicate their choices, and how are their choices respected?	**Choice**
Relationships • What opportunities do individuals have to be "givers" in relationships? • How are individuals recognized for their unique gifts and talents? • Does the individual have friends? • Are there opportunities to interact with and meet others (including individuals without disabilities who are not staff)?	**Relationships**

continued ▸

OPTIONAL ACTIVITY

Important Values *continued*

Values	*Ways to Include Values in Individuals' Daily Lives*
Regular lifestyles • Are there opportunities for participation (even if only partial) in a variety of community and social activities? • How are you assisting individuals to connect within their communities (YMCAs, community colleges, support groups, social groups, gyms, sports leagues, churches, and temples)?	**Regular lifestyles**
Health and well-being • Do the individuals you support eat healthy meals? • Are the individuals physically active? • Are the individuals supported in learning how to keep themselves healthy?	**Health and well-being**
Rights and responsibilities • How are individuals' routines and choices respected? • How well do you listen to the individuals you support? • Are individuals able to have personal privacy, especially at home? • Do individuals feel like they are living in their own homes or in a facility that is programmed and planned by staff?	**Rights and responsibilities**
Satisfaction • Are activities individuals participate in motivating and interesting to them? • Are you acknowledging individuals when they behave appropriately? • Are you giving feedback when you see positive behaviors?	**Satisfaction**

Positive Environment

All people are affected by the environment around them, both inside and outside. The weather, noise, crowds, and confusion often cause many of us discomfort. These factors also affect the individuals you support and sometimes more than you realize. Think about how you feel when you are in a place where you are not comfortable. How do you react?

When you consider the quality of the lives of individuals you support, it is important to look at the environments where they spend their time. Are there details about those environments that are causing discomfort or not meeting the needs of the individual? Think about what you like about your home and what you would not be comfortable with in any environment.

ACTIVITY

Positive Environment Video

Negative factors found in the video	***What could be done to improve the environment***

One way to examine the environment of any facility is to use a checklist.

The Positive Environment Checklist is a tool you can use to look at all aspects of the environment to determine if there are situations, conditions, or factors that contribute to any of the challenging behaviors.

ACTIVITY

Positive Environment Checklist

The Positive Environment Checklist (PEC) is designed for use in evaluating whether the settings in which individuals with moderate to severe disabilities live, work, and go to school are structured in a manner that promotes and maintains positive, adaptive behaviors. Responses to questions in each area should be based on direct observation of the environment and review of written program documents and personnel.

Three response options are provided for each question: YES, NO, and UNCLEAR. The term "staff" applies to paid and volunteer personnel who provide support and services in the setting. The term "individual" refers to the individuals with disabilities who live, work, or attend school in the setting.

- *Review each question and circle YES, NO, or UNCLEAR. Circle UNCLEAR if the answer is hard to determine, or if it is sometimes "yes" and sometimes "no."*

Source: R & T Center on Community Referenced Positive Behavior Support, University of Oregon

SECTION 1: PHYSICAL SETTING			
1. Is the physical setting clean, well lit, and odor free?	*Yes*	*No*	*Unclear*
2. Is the temperature regulation in the setting adequate?	*Yes*	*No*	*Unclear*
3. Is the physical setting visually pleasant and appealing?	*Yes*	*No*	*Unclear*
4. Does the arrangement of the setting promote easy access for all individuals within the setting?	*Yes*	*No*	*Unclear*
5. Is the setting arranged in a manner that facilitates needed staff support and supervision?	*Yes*	*No*	*Unclear*
6. Does the setting contain or provide interesting, age-appropriate items and materials for individuals to use?	*Yes*	*No*	*Unclear*
7. Is the setting located and structured in a manner that promotes and facilitates physical integration into the general community?	*Yes*	*No*	*Unclear*

continued ▶

Positive Environment Checklist *continued*

SECTION 2: SOCIAL SETTING

1. Is the number of individuals in this setting appropriate for its physical size and purpose?	*Yes*	*No*	*Unclear*
2. Are the individuals who share this setting compatible in terms of age, gender, and support needs?	*Yes*	*No*	*Unclear*
3. Do the individuals that share this setting get along with each other?	*Yes*	*No*	*Unclear*
4. Do staff actively work to develop and maintain a positive relationships with the individuals here?	*Yes*	*No*	*Unclear*
5. Do staff promote and facilitate opportunities for social integration with people who are not paid to provide service?	*Yes*	*No*	*Unclear*

SECTION 3: ACTIVITIES AND INSTRUCTION

1. Do individuals participate in a variety of different activities?	*Yes*	*No*	*Unclear*
2. Do individuals participate in activities that occur in regular community settings outside of the home, school, or workplace?	*Yes*	*No*	*Unclear*
3. Do individuals in this setting receive instruction on activities and skills that are useful and meaningful to their daily lives?	*Yes*	*No*	*Unclear*
4. Is the instruction that individuals receive individualized to meet their needs?	*Yes*	*No*	*Unclear*
5. Are individuals' personal preferences taken into account when determining the activities and tasks in which they participate and receive training?	*Yes*	*No*	*Unclear*

SECTION 4: SCHEDULING AND PREDICTABILITY

1. Is there a system or strategy used to identify what individuals in this setting would be doing and when?	*Yes*	*No*	*Unclear*
2. Is there a means to determine whether the activities or events that should be occurring actually do occur?	*Yes*	*No*	*Unclear*
3. Do individuals in this setting have a way of knowing and predicting what they will be doing and when?	*Yes*	*No*	*Unclear*
4. Do staff prepare individuals in this setting in advance for changes in typical schedules or routines?	*Yes*	*No*	*Unclear*
5. Do individuals in this setting have opportunities to exercise choice in terms of what they will do, when, and with whom and what rewards they will receive?	*Yes*	*No*	*Unclear*

continued ▶

Positive Environment Checklist *continued*

Section 5: Communication

1. Do individuals in this setting have acceptable means to communicate basic messages (for example, requests, refusals, need for attention) to staff or others in the setting?	*Yes*	*No*	*Unclear*
2. Do staff promote and reward communication?	*Yes*	*No*	*Unclear*
3. Do staff have acceptable means to communicate basic messages to the individuals in this setting?	*Yes*	*No*	*Unclear*

ACTIVITY

Debriefing the Activity

Directions: Answer the following questions about your responses on the Positive Environment Checklist.

How might the environment of your facility affect the behavior of individuals who live or work there?

What did you find out about the social setting you looked at? Did you note any problem areas? How might this affect the behavior of individuals who live or work there?

What did you find out about the activities and instructions you examined? Did you note any problem areas? How might this affect the behavior of individuals who live or work there?

What did you find out about scheduling and predictability? Did you note any problem areas? How might this affect the behavior of individuals who live or work there?

How about communication? Did you note any problem areas? How might this affect the behavior of individuals who live or work there?

Clearly, the environment can influence someone's behavior. It becomes your job to make sure the environments in which individuals live affect them in a positive way. Doing so not only improves the lives of the individuals, but makes your job easier as well.

Darrell now realizes that he has tools that he can use to help him support individuals' positive behavior at the facility in which he works.

Darrell knows how to:

- *Look at challenging behavior from all angles.*
- *Figure out what the challenging behavior is trying to communicate.*
- *Examine the quality of life of the individuals.*
- *Examine the environment.*
- *Respect and honor the individual's desires.*

PRACTICE AND SHARE

Choose one of the individuals that you support who uses challenging behaviors to communicate his or her needs and wants. Using the strategies from this session, define the specific behaviors and the communicative intent of those behaviors. See if the quality of life values are reflected in his or her everyday life and determine if the way the DSPs respond to him or her is valuing and respecting their choices and preferences. Note any of the areas that are lacking in his or her life. You will be able to use these ideas in Year 2 Positive Behavior Support sessions.

Positive Behavior Support

1	A	B	C	D
2	A	B	C	D
3	A	B	C	D
4	A	B	C	D
5	A	B	C	D
6	A	B	C	D
7	A	B	C	D
8	A	B	C	D
9	A	B	C	D
10	A	B	C	D

1. **An individual makes loud noises whenever she wants to get attention from the staff. This is an example of using behavior to:**
   A) Annoy other people unnecessarily.
   B) Have fun when there is nothing else to do.
   C) Get other people to dislike you so they won't bother you.
   D) Communicate a need or desire to other people.

2. **A DSP shows skill understanding what an individual wants or needs when the DSP is able to:**
   A) "Read" the individual's behavior and understand their communication style.
   B) Meet with the planning team and read the IPP carefully.
   C) Guess at what the individual will want or need in the future.
   D) Avoid watching the individual's facial expressions and "body language".

3. **When the DSP asks why an individual is engaged in challenging behaviors, the DSP is trying to learn:**
   A) The feelings and needs the individual is trying to express through behavior.
   B) The "communicative intent" of the individual.
   C) Possible ways of removing the cause of the challenging behaviors.
   D) All of the above.

4. **To understand "communicative intent" of an individual engaged in challenging behaviors, the DSP should try to:**
   A) Ignore the challenging behavior until the communication becomes more reasonable.
   B) Give the individual consequences for communicating in an unpleasant way.
   C) Experiment with different rewards until the communicative intent disappears.
   D) Figure out what the individual is trying to express through the behavior.

5. **Giving an individual more opportunities for privacy may sometimes influence behavior by:**
   A) Allowing the individual to remove or minimize the trigger(s) for challenging behaviors.
   B) Causing the individual to see lots of staff attention.
   C) Increasing the number of consistent consequences for negative behaviors.
   D) Increasing the social activities the individual is involved in.

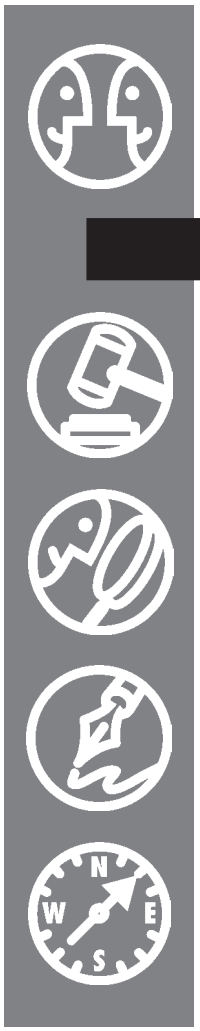
6. **When an individual with challenging behaviors is with a group of people without challenging behaviors, the behavior often improves because:**
   A) The individual's behavioral medications are better adjusted.
   B) It is easier to supervise the individual when no one else is showing challenging behaviors.
   C) Other people provide good role models for the individual.
   D) The individual no longer has a need to communicate feelings or needs.

7. **Challenging behavior usually is:**
   A) Caused when an individual is not disciplined enough.
   B) An attempt to communicate a feeling or need.
   C) The result of too many choices being given to the individual.
   D) A natural reaction to a positive environment.

8. **Behavior can be positively affected by all of the following except:**
   A) Sensitivity to ethnic and cultural values of individuals.
   B) The careful scheduling of activities in the home.
   C) Improving the physical setting in the home.
   D) Decreasing opportunities for social interaction.

9. **A social setting that can lead to more positive behaviors includes:**
   A) High staff turnover.
   B) Age-compatible peers and lots of positive interaction.
   C) Giving individuals encouragement to communicate through challenging behaviors.
   D) None of the above.

10. **Which of the following will not usually help reduce a challenging behavior?**
    A) Looking carefully at the quality of life of the person.
    B) Examining the environment in which the behavior occurs long enough to force the individual to change the behavior.
    C) Giving a "time out".
    D) Figuring out what the individual is trying to communicate.



Student Resource Guide

Resources

Resources

The DSP Profession

Resource	*Source or Website*
Members of Each Other: Building Community in Company with People with Developmental Disabilities *by O'Brien, J. and Connie Lyle (1996)* *Inclusion Press; ISBN 1-895418-24-0* *A collection of essays related to inclusion, exclusion, and building community. Also contains discussion about "circles", including potential problems. This is a practical and philosophical approach to these issues.*	*Publication*
City Parks & Recreation Programs *YMCA/YWCA* *Boys & Girls Clubs* *Boy Scouts/amp Fire USA* *Big Brother 7 Big Sisters* *Community Centers* *Libraries* *United Way Agency* *Easter Seal* *United Cerebral Palsy* *Community Colleges* *Senior Centers/Adult*	*Local Contact Agencies*
American Association on Mental Retardation *Oldest & largest interdisciplinary organization of professionals concerned about mental retardation & related disabilities.*	**aamr.org**
Association for Persons with Severe Handicaps *Association of people with disabilities, their family members, advocates & professionals concerned with independence for all individuals with disabilities.*	**tash.org**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**
Best Buddies of California *Educate high school & college students, corporate and community citizens, & employers about the needs and abilities of people with intellectual disabilities.*	**bestbuddiesca.org**

The DSP profession *(continued)*

Resource	*Source or Website*
California Attorney General's Crime & Violence Prevention Center *Preventing crime and violence in California.*	**safestate.org**
California Community Care Licensing Division *Promote the health, safety, and quality of life of each person in community care.*	**http://ccld.ca.gov**
Community Services for Autistic Adults and Children *Autism links.*	**csaac./org/links**
Council for Exceptional Children *Improve educational outcomes for individuals with exceptionalities*	**cec.ped.org/main/sitedex**
Deaf Education *Educational enhancement for the field of Deaf Education.*	**deafed.net**
Department of Developmental Services *Is the agency through which the State of California provides services and supports to children & adults with developmental disabilities.*	**dds.ca.gov**
Direct Support Professional Division-AAMR *A division of AAMR to focus on current information relevant to direct support professional staff.*	**aamr.org/groups/div/sp**
Disability Resources on the Internet *(CALIFORNIA): organization that monitors, reviews, and reports on hundreds of disability-related topics.*	**disabilityresources.org/ California**
Educational Resources Information Center *Provides information on the education of individuals with disabilities as well as those who are gifted.*	**http://ericec.org**
Institute for Community Inclusion *Supports the rights of children and adults with disabilities to participate in all aspects of the community.*	**communityinclusion.org**
President's Committee on Mental Retardation *Provide a variety of links and valuable information that may assist the public in learning more about mental retardation or accessing needed support and services in one's own local community.*	**adf.dhhs.gov/programs/ pcmr**

The DSP profession *(continued)*

Resource	*Source or Website*
Protection and Advocacy, Inc *Advancing the human and legal rights of people with disabilities.*	**pai-ca.org**
Rehabilitation Research & Training Center *(Resources on Aging for Individuals with Intellectual and or Developmental Disabilities.)*	**uic.edu/orgs**
Rehabilitation Research & Training Center-University of Illinois at Chicago *Provides information on ways to support adults with developmental disabilities and their families.*	**uic.edu/orgs/rrtcamr**
S.E.E. Center *Promote understanding of principals of Signing Exact English and its use.*	**seecenter.org**
Shift Happens (book) *Offers something for people & organizations serving individuals with disabilities as well as every parent & teacher. (Produced by ARC of Delaware.)*	**shifthappens.tv**
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
The Alliance for Direct Support Professionals *Committed to strengthening the quality of human service support by strengthening the direct support workforce.*	**nadsp.org**
The Caregiver Manual & Resource Guide for Southwest Florida *Purpose of this manual is to enhance your life as a caregiver/service provider.*	**fgcu.edu/dfpa/manual**
The Quality Mall *Collect and disseminate information related to or useful in promoting quality of life for persons with developmental disabilities.*	**qualitymall.org**
United Cerebral Palsy *Is the leading source of information of cerebral palsy and is a pivotal advocate for the rights of persons with any disability.*	**ucpa.org**

Information on Developmental Disabilities

Resource	*Source or Website*
Members of Each Other: Building Community in Company with People with Developmental Disabilities *by O'Brien, J. and Connie Lyle (1996)* *Inclusion Press; ISBN 1-895418-24-0* *A collection of essays related to inclusion, exclusion, and building community. Also contains discussion about "circles", including potential problems. This is a practical and philosophical approach to these issues.*	*Publication*
ADA Hot links and Document Center *language description of ADA and its content. (International Center for disability Information at West Virginia University)*	**jan.wvu.edu/links/** *Plain* **adalinks**
American Association on Mental Retardation *Oldest & largest interdisciplinary organization of professionals concerned about mental retardation & related disabilities.*	**aamr.org**
American Speech–Language Hearing Association *To ensure that all people with speech, language, and hearing disorders have access to quality services to help them communicate more effectively.*	**asha.org/public**
ARC-National *Works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community.*	**thearc.org**
Association for Persons with Severe Handicaps *Association of people with disabilities, their family members, advocates & professionals concerned with independence for all individuals with disabilities.*	**tash.org**
Association of Regional Center Agencies *Advocate in promoting the continuing entitlement of individuals with developmental disabilities to all services that enable full community inclusion.*	**arcanet.org**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**

Information on Developmental Disabilities *(continued)*

Resource	*Source or Website*
Best Buddies of California *Educate high school & college students, corporate and community citizens, & employers about the needs and abilities of people with intellectual disabilities.*	**bestbuddiesca.org**
California Attorney General's Crime & Violence Prevention Center *Preventing crime and violence in California.*	**safestate.org**
California Dept. of Aging *Working primarily with the area agencies on Aging who serve seniors, adults with disabilities, and caregivers.*	**aging.state.ca.us**
California State Independent Living Council *Philosophy of people with disabilities who work for self-determination, equal opportunities and self-respect.*	**calsilc.org**
Consumer Product Safety Commission *Works to save lives and keep families safe by reducing the risk of injuries and deaths associated with consumer products.*	**cpsc.gov**
Deaf Education *Educational enhancement for the field of Deaf Education.*	**deafed.net**
Direct Support Professional Division-AAMR *A division of AAMR to focus on current information relevant to direct support professional staff.*	**aamr.org/groups/div/sp**
Disability Resources on the Internet *(CALIFORNIA): organization that monitors, reviews, and reports on hundreds of disability-related topics.*	**disabilityresources.org/ California**
Educational Resources Information Center *Provides information on the education of individuals with disabilities as well as those who are gifted.*	**http://ericec.org**
Epilepsy Foundation *Seek to ensure that people with seizures are able to participate in all life experiences and prevent, control and cure epilepsy.*	**epilepsyfoundation.org**
Independent Living Resource Center of San Francisco *To ensure that people with disabilities are full social and economic partners, both within their families and in a fully accessible community.*	**ilfcsfl.org**

Information on Developmental Disabilities *(continued)*

Resource	*Source or Website*
Institute for Community Inclusion *Supports the rights of children and adults with disabilities to participate in all aspects of the community.*	**communityinclusion.org**
National Down Syndrome Society *The Internet's most comprehensive information source on Down Syndrome.*	**ndss.org**
National Dual Diagnosis Association *Advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.*	**thenadd.org**
National Rehabilitation Information Center for Independence *Comprehensive database for disability and rehabilitation resources.*	**naric.com/sitemap**
New York Access to Health: NOAH *A partnership project which provides online access to high quality full-text consumer health information.*	**noah-health.org**
Office of Special Education & Rehabilitative Services *Committed to improving results and outcomes for people with disabilities of all ages.*	**ed.gov/offices/osers**
President's Committee on Mental Retardation *Provide a variety of links and valuable information that may assist the public in learning more about mental retardation or accessing needed support and services in one's own local community.*	**adf.dhhs.gov/programs/pcmr**
Rehabilitation Research & Training Center-University of Illinois at Chicago *Provides information on ways to support adults with developmental disabilities and their families.*	**uic.edu/orgs/rrtcamr**
Safe USA *This website is being developed for the public & community groups to provide access to information & resources provided by many organizations that work to prevent injuries.*	**safeusa.org**
Shift Happens (book) *Offers something for people & organizations serving individuals with disabilities as well as every parent & teacher. (Produced by ARC of Delaware.)*	**shifthappens.tv**

Information on Developmental Disabilities *(continued)*

Resource	*Source or Website*
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
Special Education Technology British Columbia *Assertive device resource directory*	**setbc.org/setinfo**
Special Olympics of California *Sports training & competition in a variety of Olympic-type sports for people eight years and older with developmental disabilities*	**sonc.org** (Northern California) **sosc.org** (Southern California)
Spine Universe *Maintaining a healthy spine through good body mechanics and accurate information.*	**spineuniverse.com**
State Council on Developmental Disabilities *Assist in planning, coordinating, monitoring & evaluating services for individuals with developmental disabilities and their families.*	**scdd.ca.gov/ resources_links**
State Office of Emergency Services (California) *Supporting special needs and vulnerable populations in disasters.*	**preparenow.org/prepare**
The Alliance for Direct Support Professionals *Committed to strengthening the quality of human service support by strengthening the direct support workforce.*	**nadsp.org**
Transition Link *Sharing ideas, strategies, resources, and information concerning the transition to life after high school for adolescents with disabilities.*	**transitionlink.com**
United Cerebral Palsy *Is the leading source of information of cerebral palsy and is a pivotal advocate for the rights of persons with any disability.*	**ucpa.org**
U.S. Fall Prevention Program for Seniors *Selected programs using home assessment and modification.*	**cdc.gov/ncipc/fall**
U.S. Fire Administration *Information you need to decide what you must do to protect your family from fire.*	**usfa.fema.gov**

Information on Developmental Disabilities *(continued)*

Resource	*Source or Website*
United States Fire Administration- (Kids fire safety web site) *Tips that can help you and your family be safe from fire.*	**usfa.fema.gov/kids**
U.S. Food & Drug Administration *Reviewing clinical research; promote public health to ensure foods are safe sanitary and properly labeled.*	**fda.gov**

The California Developmental Disabilities Service System

Resource	***Source or Website***
California Community Care Licensing Division *Promote the health, safety, and quality of life of each person in community care.*	**http://ccld.ca.gov**
Department of Developmental Services *Is the agency through which the State of California provides services and supports to children & adults with developmental disabilities.*	**dds.ca.gov**
Protection and Advocacy, Inc *Advancing the human and legal rights of people with disabilities.*	**pai-ca.org**

Risk Management

Resource	*Source or Website*
Assessing Health Risk in Developmental Disabilities by Karen Green McGowan & Jim McGowan (1995); McGowan Publications. *This book explains the rationale and use of the KMG Fragility Scale. Mcgowanconsultants.com*	Publication
Disaster Preparedness for People with Disabilities by American Red Cross Disaster Services (1996) A self-instructional manual for people with disabilities. *It contains a number of exercises and checklists and includes a number of considerations (for example, protecting one's assistance dog) not found in more generic guides.*	Publication
First Aid Fast by American Red Cross (1995); Stay Well Printer; ISBN: 0815102585. *This booklet, complete with pictures and diagrams, indicates what to do in a variety of emergency situations.*	Publication
Hazards at Home by Bill Gutman (1996); Twenty-First century Books; ISBN:0805041419. *This book deals with fall, fires and burns, poisons, firearms, swimming pools and other drowning dangers, tools and machinery, and how to help in case of an accident.*	Publication
Poison! How to Handle the Hazardous Substances in Your Home by Jim Morelli (1997); Andrews and McMeel; ISBN: 083622721. *The back cover begins: "You live in a toxic dump. There's no getting around it. If you wash dishes, do laundry, or clean the toilet, oven, or sink, chances are good that you use a poisonous material to do it." Morelli worked in a Poison Control Center, and thus has first-hand knowledge of the kinds of work involved.*	Publication
Wellness Digest, Vol. 1, No. 2 by California Department of Developmental Services *This issue is devoted to medication administration. Ed Anamizu, PharmD, served as consulting editor and was assisted by Mary Jann, R.N. both have extensive background and experience with medication usage by people with developmental disabilities.*	Publication

Risk Management *(continued)*

Resource	*Source or Website*
American Red Cross *Provides locally relevant humanitarian services that help people within the community be safer, healthier and more self-reliant.*	**redcross.org**
California Attorney General's Crime & Violence Prevention Center *Preventing crime and violence in California.*	**safestate.org**
California Community Care Licensing Division *Promote the health, safety, and quality of life of each person in community care.*	**http://ccld.ca.gov**
California Poison Control System *A toll-free 800 number is available to all areas of California by calling 1-800-876-4766 anywhere in California, you can obtain emergency information.*	**calpoison.org**
Consumer Product Safety Commission *Works to save lives and keep families safe by reducing the risk of injuries and deaths associated with consumer products.*	**cpsc.gov**
Safe USA *This website is being developed for the public & community groups to provide access to information & resources provided by many organizations that work to prevent injuries.*	**safeusa.org**
Spine Universe *Maintaining a healthy spine through good body mechanics and accurate information.*	**spineuniverse.com**
State Office of Emergency Services (California) *Supporting special needs and vulnerable populations in disasters.*	**Preparenow.org/prepare**
U.S. Fall Prevention Program for Seniors *Selected programs using home assessment and modification.*	**cdc.gov/ncipc/fall**
U.S. Fire Administration *Information you need to decide what you must do to protect your family from fire.*	**usfa.fema.gov**

Risk Management *(continued)*

Resource	*Source or Website*
United States Fire Administration- (Kids fire safety web site) *Tips that can help you and your family be safe from fire.*	**usfa.fema.gov/kid**
U.S. Food & Drug Administration *Reviewing clinical research; promote public health to ensure foods are safe, sanitary and properly labeled.*	**fda.gov**

Health/Wellness

Resource	*Source or Website*
A Parent's Guide to Medical Emergencies by Janet Zand, Rachel Walton, and Bob Roundtree (1997); Avery Publishing Group; ISBN: 0895297361. *This book provides guidance for parents in meeting the emergency needs of their children.*	Publication
Complete Guide to Prescription & Nonprescription Drugs by H. Winter Griffith 2001 (Serial) (Pedigree: November 1998), $10-$20. 2004 Edition will be released on November 4, 2003. *Psychotropic Medications in Persons with Developmental Disabilities, an overview for families and other are providers written by Dr. Bryan King, in booklet published by Frank D, Lanterman Regional Center*	Publication
Dangerous Drug Interactions: The People's Pharmacy Guide by Joe Graedon & Teresa Graedon (1999); St. Martin's Press revised edition, ISBN:0312968264 *This book summarizes much of what is known about drug interaction, not only with other medications (both prescription and Over-The–counter), but with foods, vitamins and minerals, herbs, and alcohol. One chapter on drug interaction of particular interest to women, children, and the elderly. Excellent index. Dean Edell, M.D., Medical Journalist in San Franscisco, says: "At last , someone has tackled this most complex and critical area. Only the Graedons could make this clear and understandable. A "must have" for anyone interested in their health."*	Publication
FDA Tips for Taking Medicines: How to Get the Most Benefit with the Fewest Risks by U.S. Food and drug administration (n.d.); reprint Publication No. FDA 96-3221. Write FDA, 5600 Fishers Lane, Rockville, MD 20856, Attn:HFE-88, *This reprint includes a patient check-off chart for help in taking medications at the right time. Special sections advise patients on medications while in the hospital, protection against tampering, medication counseling, and tips for giving medicine to children. Single copy free.*	Publication

Health/Wellness *(continued)*

Resource	*Source or Website*
Health and Wellness Reference Guide by Smith Consultant Group and McGowan Consultants; developed for the Commission on Compliance, State of Tennessee (July 1998). *This is a general reference for nurses and others working with direct care staff in various settings.*	Publication
Physician's Desk Reference, The PDR Family Guide to Over-The-Counter Drugs (Three Rivers Press: December 1998), $15-$25. *Most bookstores will have the PDR (Physician's Desk Reference), which is the most comprehensive source of information on prescription drugs. It is fairly expensive ($75-$100). There are a number of other excellent sources. Ask the individual's physician or pharmacist to recommend one.*	Publication
Pocket Guide to Prescription Drugs *(*Pocket Books: January 1999), $50%10.00	Publication
Poison! How to Handle the Hazardous Substances in Your Home by Jim Morelli (1997); Andrews and McMeel; ISBN: 083622721. *The back cover begins: "You live in a toxic dump. There's no getting around it. If you wash dishes, do laundry, or clean the toilet, oven, or sink, chances are good that you use a poisonous material to do it." Morelli worked in a Poison Control Center, and thus has first-hand knowledge of the kinds of work involved.*	Publication
The American Pharmaceutical Association's Guide to Prescription Drugs by Donald Sullivan, Ph.D., R.P.h (1998); A Signet Book; ISBN: 0451199438 *Written in clear, easy-to-understand language, and organized alphabetically, this book provides the most up-to-date information you need to know about the most commonly prescribed drugs.* *$5-$10.00*	Publication
The Pill Book: The Illustrated Guide to the Most–Prescribed Drugs in the United States (1998), by Silverman, Harold M., editor. Bantam books.	Publication
The Pill Book Guide to Over-The-Counter Medications (1997) by Rapp, Robert P., editor. Bantam books.	Publication

Health/Wellness *(continued)*

Resource	*Source or Website*
AARP Health and Wellness *Healthy tips on exercise, eating right, and personal care.*	**aarp.org/health**
About Smiles *Promote oral health for children and adults with special needs.*	**aboutsmiles.org/special**
American Dietetic Association *Provides nutrition information with news releases and consumer tips- Nutrition Fact Sheets and the Good Nutrition reading List.*	**eatright.org**
California Dental Association *Value oral health and expand the communities understanding of the importance of preventative and restorative and dental are services.*	**cda.org**
California Dept. of Aging *Working primarily with the area agencies on Aging who serve seniors, adults with disabilities, and caregivers.*	**aging.state.ca.us**
California Poison Control System *A toll-free 800 number is available to all areas of California by calling 1-800-876-4766 anywhere in California, you can obtain emergency information.*	**calpoison.org**
Center for Disease Control- Disability & Health *Promote the health and well being of the estimated 54 million people with disabilities living in the United States.*	**cdc.gov/ncbddd/dh**
Centers for Disease Control and Prevention *Lead federal agency for protecting the health and safety of people-providing credible information to enhance health decisions, and promoting health through strong partnerships.*	**cdc.gov** **cdc.gov/health**
Consumer Product Safety Commission *Works to save lives and keep families safe by reducing the risk of injuries and deaths associated with consumer products.*	**cpsc.gov**
Consumer Reports - Health *Personal care, food & beverages, health and fitness.*	**consumerreports.org**

Health/Wellness *(continued)*

Resource	*Source or Website*
Disability Resources on the Internet *(CALIFORNIA): organization that monitors, reviews, and reports on hundreds of disability-related topics.*	**disabilityresources.org/ California**
Epilepsy Foundation *Seek to ensure that people with seizures are able to participate in all life experiences and prevent, control and cure epilepsy.*	**epilepsyfoundation.org**
Healthy People 2010 – Leading Health Indicators *Illustrate individual behaviors, physical and social environmental factors, and important health systems issues that greatly affect the health of individuals and communities.*	**Healthypeople.gov/Ihi**
Kaiser Permanente – Healthwise Handbook *A self-care guide for you and your family.*	**Permanente.net/handbook**
Mayo Clinic – Health & Medical Information *Information on health and medical topics.*	**Mayoclinic.org/ healthinfo**
New York Access to Health: NOAH *A partnership project which provides online access to high quality full-text consumer health information.*	**noah-health.org**
Safe Medication *Database can help you find the important information you need to use medications safely and effectively.*	**safemedication.com**
Safe USA *This website is being developed for the public & community groups to provide access to information & resources provided by many organizations that work to prevent injuries.*	**safeusa.org**
Spine Universe *Maintaining a healthy spine through good body mechanics and accurate information.*	**spineuniverse.com**
Stay Well *Community Resources for California's Seniors.*	**Aging.state.ca.us/ (related links-Tip Sheets)**
UC Berkeley Wellness Letter *Variety of subjects related to food and nutrition, exercise, self-care, preventive medicine, and emotional well-being.*	**berkeleywellness.com**

Health/Wellness *(continued)*

Resource	*Source or Website*
UCSD Healthguide *Comprehensive collection of features and health news; all you need to know to keep you and your family healthy.*	**htpp://health.ucsd.edu/guide**
U.S. Food & Drug Administration *Reviewing clinical research; promote public health to ensure foods are safe, sanitary and properly labeled.*	**fda.gov**
Web MD *Valuable health information, tools for managing your health, and support to those seeking information.*	**webmd.com**

Communication

Resource	*Source or Website*
Members of Each Other: Building Community in Company with People with Developmental Disabilities by O'Brien, J. and Connie Lyle (1996) Inclusion Press; ISBN 1-895418-24-0 *A collection of essays related to inclusion, exclusion, and building community. Also contains discussion about "circles", including potential problems. This is a practical and philosophical approach to these issues.*	Publication
ADA Hot Links and Document Center *Plain language description of ADA and its content. (International Center for disability Information at West Virginia University)*	**jan.wvu.edu/links/adalinks**
American Dietetic Association *Provides nutrition information with news releases and consumer tips- Nutrition Fact Sheets and the Good Nutrition reading List.*	**eatright.org**
American Speech–Language Hearing Association *To ensure that all people with speech, language, and hearing disorders have access to quality services to help them communicate more effectively.*	**asha.org/public**
ARC-National *Works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community.*	**thearc.org**
Assistive Technology, Inc. *Assistive Technology, Inc. serves the disability and special education markets by providing innovative software and hardware solutions for people with special needs and for the professionals who work with them.*	**www.assistivetech.com**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**
Deaf Education *Educational enhancement for the field of Deaf Education.*	**deafed.net**

Communication *(continued)*

Resource	*Source or Website*
Educational Resources Information Center *Provides information on the education of individuals with disabilities as well as those who are gifted.*	**http://ericec.org**
Office of Special Education & Rehabilitative Services *Committed to improving results and outcomes for people with disabilities of all ages.*	**ed.gov/offices/osers**
President's Committee on Mental Retardation *Provide a variety of links and valuable information that may assist the public in learning more about mental retardation or accessing needed support and services in one's own local community.*	**adf.dhhs.gov/programs/pcmr**
Rehabilitation Research & Training Center- *(Resources on Aging for Individuals with Intellectual and or Developmental Disabilities.)*	**uic.edu/orgs**
Rehabilitation Research & Training Center-University of Illinois at Chicago: *Provides information on ways to support adults with developmental disabilities and their families.*	**uic.edu/orgs/rrtcamr**
RJ Copper & Associates *Software and hardware for Persons with Special Needs.*	**www.rjcooper.com**
S.E.E. Center *Promote understanding of principals of Signing Exact English and its use.*	**seecenter.org**
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
Special Education Technology British Columbia *Assertive device resource directory*	**setbc.org/setinfo**
The Quality Mall *Collect and disseminate information related to or useful in promoting quality of life for persons with developmental disabilities.*	**qualitymall.org**
United Cerebral Palsy *Is the leading source of information of cerebral palsy and is a pivotal advocate for the rights of persons with any disability.*	**ucpa.org**

Positive Behavior Support

Resource	*Source or Website*
Functional Analysis of Problem Behavior: From Effective Assessment to Effective Support. by Repp, A.C. & Horner, N.N. (1999). Belmont, CA: Wadsworth Publishing	Publication
Functional Assessment and Program Development for Problem Behavior Support and Teaching Strategies by O'Neill, R., Horner, R., Albin, R., Storey., K., and Spreage, J. (1997) Pacific Grove, Brooks/Cole Publishing. (800) 345-9706	Publication
Nonaversive Intervention for Behavior Problem by Meyer, L.H., & Evans, I.M. (1989) A manual for home and Community Baltimore: Paul H. Brookes Publishers	Publication
Positive Behavioral Support by Kincaid, D., (1996) (Including People with Difficult Behavior in the Community. Baltimore, MD: Paul H. Brookes Publishers	Publication
Ten Ways to Support a Person with Challenging Behavior Fact Sheet (1999) The Beach Center on Disability The University of Kansas, Lawrence, Kansas Excerpted from: Pitonyak, D. (1997) **10 Things You Can Do to Support a Person with Difficult Behaviors.** The Community Journal, Blacksberg, VA PBS-FS-009-2000	Publication
American Association on Mental Retardation *Oldest & largest interdisciplinary organization of professionals concerned about mental retardation & related disabilities.*	**aamr.org**
American Red Cross *Provides locally relevant humanitarian services that help people within the community be safer, healthier and more self-reliant.*	**redcross.org**
ARC-National *Works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community.*	**thearc.org**

Positive Behavior Support *(continued)*

Resource	*Source or Website*
Association for Persons with Severe Handicaps *Association of people with disabilities, their family members, advocates & Professionals concerned with independence for all individuals with disabilities.*	**tash.org**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**
California Community Care Licensing Division *Promote the health, safety, and quality of life of each person in community care.*	**http://ccld.ca.gov**
California State Independent Living Council *Philosophy of people with disabilities who work for self-determination, equal opportunities and self-respect.*	**calsilc.org**
Community Services for Autistic Adults and Children *Autism links.*	**csaac./org/links**
Council for Exceptional Children *Improve educational outcomes for individuals with exceptionalities*	**cec.ped.org/main/sitedex**
Deaf Education *Educational enhancement for the field of Deaf Education.*	**deafed.net**
Department of Developmental Services *Is the agency through which the State of California provides services and supports to children & adults with developmental disabilities.*	**dds.ca.gov**
Disability Resources on the Internet *(CALIFORNIA): organization that monitors, reviews, and reports on hundreds of disability-related topics.*	**disabilityresources.org/ California**
Educational Resources Information Center *Provides information on the education of individuals with disabilities as well as those who are gifted.*	**http://ericec.org**
Epilepsy Foundation *Seek to ensure that people with seizures are able to participate in all life experiences and prevent, control and cure epilepsy.*	**epilepsyfoundation.org**

Positive Behavior Support *(continued)*

Resource	*Source or Website*
Independent Living Resource Center of San Francisco *To ensure that people with disabilities are full social and economic partners, both within their families and in a fully accessible community.*	**ilfcsfl.org**
Institute for Community Inclusion *Supports the rights of children and adults with disabilities to participate in all aspects of the community.*	**communityinclusion.org**
National Down Syndrome Society *The Internet's most comprehensive information source on Down Syndrome.*	**ndss.org**
National Dual Diagnosis Association *Advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.*	**thenadd.org**
National Rehabilitation Information Center for Independence *Comprehensive database for disability and rehabilitation resources.*	**naric.com/sitemap**
New York Access to Health: NOAH *A partnership project which provides online access to high quality full-text consumer health information.*	**noah-health.org**
Office of Special Education & Rehabilitative Services *Committed to improving results and outcomes for people with disabilities of all ages.*	**ed.gov/offices/osers**
President's Committee on Mental Retardation *Provide a variety of links and valuable information that may assist the public in learning more about mental retardation or accessing needed support and services in one's own local community.*	**adf.dhhs.gov/programs/pcmr**
Protection and Advocacy, Inc *Advancing the human and legal rights of people with disabilities.*	**pai-ca.org**
Rehabilitation Research & Training Center- *(Resources on Aging for Individuals with Intellectual and or Developmental Disabilities.)*	**uic.edu/orgs**

Positive Behavior Support *(continued)*

Resource	*Source or Website*
Rehabilitation Research & Training Center-University of Illinois at Chicago: *Provides information on ways to support adults with developmental disabilities and their families.*	**uic.edu/orgs/rrtcamr**
Shift Happens: (book) *Offers something for people & organizations serving individuals with disabilities as well as every parent & teacher. (Produced by ARC of Delaware.)*	**shifthappens.tv**
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
Special Education Technology British Columbia *Assertive device resource directory*	**setbc.org/setinfo**
State Council on Developmental Disabilities *Assist in planning, coordinating, monitoring & evaluating services for individuals with developmental disabilities and their families.*	**scdd.ca.gov/resources links**
The Alliance for Direct Support Professionals *Committed to strengthening the quality of human service support by strengthening the direct support workforce.*	**nadsp.org**
The Caregiver Manual & Resource Guide for Southwest Florida *Purpose of this manual is to enhance your life as a caregiver/service provider.*	**fgcu.edu/dfpa/manual**
The Quality Mall *Collect and disseminate information related to or useful in promoting quality of life for persons with developmental disabilities.*	**qualitymall.org**
Transition Link *Sharing ideas, strategies, resources, and information concerning the transition to life after high school for adolescents with disabilities.*	**transitionlink.com**
United Cerebral Palsy *Is the leading source of information of cerebral palsy and is a pivotal advocate for the rights of persons with any disability.*	**ucpa.org**

Positive Behavior Support *(continued)*

Resource	*Source or Website*
Office of Special Education (OSEP), US Department of Education, Positive Behavorial Interventions and Supports. *Technical assistance website.*	**Pbis.org/English/links**
Web site of good information on PBS	**beachcenter@ku.edu**
Beach Center on Disability *The University of Kansas* *Haworth Hall, Room 3136* *1200 Sunnyside Avenue* *Lawrence, KS 66045-7534* *Phone: 785-864-7600* *Fax: 785-864-7605*	**www.beachcenter.org**
Association for Positive Behavior Support- *An organization dedicated to the advancement of positive support behavior. Resource website.*	**Bridges4kids.org**

Person-Centered Planning

Resource	*Source or Website*
American Association on Mental Retardation *Oldest & largest interdisciplinary organization of professionals concerned about mental retardation & related disabilities.*	**aamr.org**
ARC-National *Works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community.*	**thearc.org**
Association for Persons with Severe Handicaps *Association of people with disabilities, their family members, advocates & professionals concerned with independence for all individuals with disabilities.*	**tash.org**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**
California Community Care Licensing Division *Promote the health, safety, and quality of life of each person in community care.*	**http://ccld.ca.gov**
California State Independent Living Council *Philosophy of people with disabilities who work for self-determination, equal opportunities and self-respect.*	**calsilc.org**
Community Services for Autistic Adults and Children *Autism links.*	**csaac./org/links**
Council for Exceptional Children *Improve educational outcomes for individuals with exceptionalities*	**cec.ped.org/main/sitedex**
Department of Developmental Services *Is the agency through which the State of California provides services and supports to children & adults with developmental disabilities.*	**dds.ca.gov**
Disability Resources on the Internet *(CALIFORNIA): organization that monitors, reviews, and reports on hundreds of disability-related topics.*	**disabilityresources.org/ California**
Educational Resources Information Center *Provides information on the education of individuals with disabilities as well as those who are gifted.*	**http://ericec.org**

Person-Centered Planning *(continued)*

Resource	*Source or Website*
Epilepsy Foundation *Seek to ensure that people with seizures are able to participate in all life experiences and prevent, control and cure epilepsy.*	**epilepsyfoundation.org**
Independent Living Resource Center of San Francisco *To ensure that people with disabilities are full social and economic partners, both within their families and in a fully accessible community.*	**ilfcsfl.org**
Institute for Community Inclusion *Supports the rights of children and adults with disabilities to participate in all aspects of the community.*	**communityinclusion.org**
National Down Syndrome Society *The Internet's most comprehensive information source on Down Syndrome.*	**ndss.org**
National Dual Diagnosis Association *Advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.*	**thenadd.org**
National Rehabilitation Information Center for Independence *Comprehensive database for disability and rehabilitation resources.*	**naric.com/sitemap**
Office of Special Education & Rehabilitative Services *Committed to improving results and outcomes for people with disabilities of all ages.*	**ed.gov/offices/osers**
Protection and Advocacy, Inc *Advancing the human and legal rights of people with disabilities.*	**pai-ca.org**
President's Committee on Mental Retardation *Provide a variety of links and valuable information that may assist the public in learning more about mental retardation or accessing needed support and services in one's own local community.*	**adf.dhhs.gov/programs/pcmr**
Rehabilitation Research & Training Center- *(Resources on Aging for Individuals with Intellectual and or Developmental Disabilities.)*	**uic.edu/orgs**

Person-Centered Planning *(continued)*

Resource	*Source or Website*
Shift Happens: (book) *Offers something for people & organizations serving individuals with disabilities as well as every parent & teacher. (Produced by ARC of Delaware.)*	**shifthappens.tv**
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
Special Education Technology British Columbia *Assertive device resource directory*	**setbc.org/setinfo**
State Council on Developmental Disabilities *in planning, coordinating, monitoring & evaluating services for individuals with developmental disabilities and their families.*	**scdd.ca.gov/resources_links** *Assist*
The Caregiver Manual & Resource Guide for Southwest Florida *Purpose of this manual is to enhance your life as a caregiver/service provider.*	**fgcu.edu/dfpa/manual**
The Quality Mall *Collect and disseminate information related to or useful in promoting quality of life for persons with developmental disabilities.*	**qualitymall.org**
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Instruction/Training & Development

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Association for Persons with Severe Handicaps *Association of people with disabilities, their family members, advocates & professionals concerned with independence for all individuals with disabilities.*	**tash.org**
Association of University Centers on Disabilities *AUCD members train and educate the next generation of leaders in disability-related research, training, service delivery, and policy advocacy.*	**aucd.org**
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Deaf Education *Educational enhancement for the field of Deaf Education.*	**deafed.net**
Department of Developmental Services *Is the agency through which the State of California provides services and supports to children & adults with developmental disabilities.*	**dds.ca.gov**
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Instructional/Training & Development *(continued)*

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National Dual Diagnosis Association *Advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.*	**thenadd.org**
New York Access to Health: NOAH *A partnership project which provides online access to high quality full-text consumer health information.*	**noah-health.org**
Rehabilitation Research & Training Center- *(Resources on Aging for Individuals with Intellectual and or Developmental Disabilities.)*	**uic.edu/orgs**
Rehabilitation Research & Training Center-University of Illinois at Chicago: *Provides information on ways to support adults with developmental disabilities and their families.*	**uic.edu/orgs/rrtcamr**
Shift Happens: (book) *Offers something for people & organizations serving individuals with disabilities as well as every parent & teacher. (Produced by ARC of Delaware.)*	**shifthappens.tv**
Special Education Resources on the Internet *Is a collection of Internet accessible information resources of interest to those involved in the fields related to Special Education.*	**seriweb.com**
Special Education Technology British Columbia *Assertive device resource directory*	**setbc.org/setinfo**

Instructional/Training & Development *(continued)*

Resource	*Source or Website*
The Alliance for Direct Support Professionals *Committed to strengthening the quality of human service support by strengthening the direct support workforce.*	**nadsp.org**
The Caregiver Manual & Resource Guide for Southwest Florida *Purpose of this manual is to enhance your life as a caregiver/service provider.*	**fgcu.edu/dfpa/manual**
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Transition Link *Sharing ideas, strategies, resources, and information concerning the transition to life after high school for adolescents with disabilities.*	**transitionlink.com**